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ABSTRACT

Four aspects of 478 residential care facilities for children and youth in Flordia, Wisconsin, and New Jersey were examined. In addition, GAO looked at records of 539 children to illuminate the issue of how individuals are placed in residential care. Aspects examined were: (1) characteristics of residential facilities; (2) funding sources for these facilities; (3) types of children served by the facilities and their characteristics; and (4) factors influencing the placement process by which children reach residential care. To conduct the investigation, a method called Program Operations and Delivery of Services Examination (PODSE), which provides a "snapshot" of program operations at one point in time, was used. All residential care facilities providing services to children in the three states were surveyed by mail; case records on 539 children in residential care across the three states were reviewed. Findings indicated that children with higher levels of previous residential care, Medicaid eligibility, or histories of abuse or criminality tended to have government agencies involved in their placements; children with fewer of these characteristics were more likely to be placed without such involvement. Children whose families had private medical insurance were more likely to be placed without government involvement than were other children. White children were more likely to be placed in privately operated facilities than were nonwhite children, who, more typically, were placed in public facilities. (RH)

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BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Honorable George Miller, Chairman Select Committee on Children, Youth, and Families House Of Representatives

ED264955

Residential Care: Patterns Of Child Placement In Three States

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Children in need of a variety of services that cannot be provided in their home environments are often placed in public or private residential care facilities. GAO, in a study conducted in three states, found certain characteristics of children and their families to be associated with both how and where residential placements were made.

Specifically, children with higher levels of previous residential care, Medicaid eligibility, or histories of abuse or criminality tended to have government agencies involved in their placements; children with fewer of these characteristics were more likely to be placed without such involvement. In addition, GAO found that children whose families had private medical insurance were more likely to be placed without government involvement than were other children.

With respect to where placements are made, GAO found that white children were more likely to be placed in privately operated facilities than were nonwhite children, who, more typically, were placed in public facilities.

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WASHINGTON, D.C. 20548

PROGRAM EVALUATION
AND
METHODOLOGY DIVISION

B-214416

The Honorable George Miller, Chairman
Select Committee on Children, Youth,
and Families
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we examine four aspects of residential care for children and youth: characteristics of residential facilities; the sources of funds used to support these facilities; the types of children served by the facilities and their characteristics; and factors which influence the placement process by which children reach residential care.

A draft of this report was reviewed by state and county officials of the three states in which the study was conducted.

As you requested, we plan no further distribution of the report until 30 days from the date of its release to you. At that time, we will send copies to individuals and organizations with interest in the area of youth services that we identified in the course of our work.

Sincerely yours,

Eleanor Chelimsky
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE HONORABLE
GEORGE MILLER
HOUSE OF REPRESENTATIVES

RESIDENTIAL CARE: PATTERNS OF CHILD PLACEMENT IN THREE STATES

DIGEST

Children in need of medical care, shelter, or detention that their families cannot provide may require placement in a residential facility to receive those services. Providing such care is primarily a state responsibility, but recent years have seen considerable federal involvement. In addition to legislating and handing down judicial decisions in the matter, the federal government funds services for youth in residential care.

In response to a congressional request, the General Accounting Office (GAO) examined 478 residential care facilities in three states to describe both those facilities and the children they serve. In addition, GAO looked at records of 539 children to illuminate the issue of how individuals are placed in residential care.

Among the major findings of GAO's study: Support of residential care comes largely from public funds; a large percentage of children placed are adolescent males; children placed through governmental processes differ in significant respects from those placed without governmental involvement; and most children, at the end of their stay, return to their families.

Although the findings cannot be generalized nationally, GAO believes that they present a framework for further study of how America cares for its institutionalized children.

OBJECTIVES, SCOPE, AND METHODOLOGY

When Representative George Miller asked GAO to analyze patterns of placement of children and youth in a variety of residential care facilities, he posed four questions:

1. What is the profile of existing residential care facilities (i.e., mental health treatment programs, inpatient chemical dependency programs, group foster homes, and juvenile correctional facilities)?

2. What are the sources of the funds used to support these facilities (e.g., private payments, state or federal funds, third-party payments)?

3. What are the characteristics of the populations served at these facilities?

4. What factors influence the placement of juveniles in each type of facility?

This report presents GAO's response to Representative Miller's inquiry.

Because this study was done at congressional request, its primary intended audience is at the federal level. Residential care for children, however, is primarily a state responsibility, shared by the private sector.

GAO believes that the information produced will be useful also to state and local legislators and officials concerned with child care, to managers of placement programs, and to others in the child care community.

Given the primacy of states and their varied approaches to residential care, GAO decided to make its investigation at the state level. GAO and congressional staff jointly chose the states to study: Florida, New Jersey, and Wisconsin. Each of the three had between 100 and 200 facilities, was located in a different geographical region, and varied in the extent to which the residential care function was centralized (pp. 4-6).

To conduct its study, GAO used a method called Program Operations and Delivery of Services Examination (PODSE), which provides a "snapshot" of program operations at one point in time. It does not, however, permit generalizations beyond the scope of the selected sites.

The design of data collection and analysis was determined by the four congressional questions. To address the first two, GAO surveyed by mail in the fall of 1983, all residential care facilities that provided services to children in the three study states. Data from this survey were used by GAO to respond to the third question as well, although a more complete treatment of the funding issue is contained in another report now being prepared for Representative Miller by GAO's Human Resources

Division (GAO/HRD-85-62). Nearly nine out of ten facilities responded; this permitted GAO to generalize its findings to the state level.

GAO analyzed the characteristics of the facilities, the populations they served, and their funding sources by three dimensions: state, category or "stream" of care (i.e., welfare, justice, and health), and whether the facilities were under public or private auspice.

To answer the fourth question, concerning placement of individuals, GAO reviewed case records on 539 children in residential care across the three states. GAO compared governmental placements (those involving government agencies or officials) and nongovernmental, focusing on the factors associated with each. Findings based on these data (also collected in the fall of 1983) apply only to the cases reviewed and are not generalizable to other populations.

A draft of the report was sent for review to state and county officials with responsibility in the area. These reviewers generally agreed with the principal findings of the GAO study.

FINDINGS: RESIDENTIAL CARE FACILITIES PROFILED

Of the 478 facilities studied, 195 were located in Florida, 157 in Wisconsin, and 126 in New Jersey. For these facilities, GAO found that

- in both Florida and Wisconsin, residential care facilities were predominantly private, while New Jersey had equal numbers of public and private facilities;

- most Wisconsin facilities were in the welfare stream, while in New Jersey and Florida, the largest numbers were in the health stream;

- most facilities in the welfare and health streams were private; in justice, the overwhelming majority were public;

- public facilities and those in the justice stream had the shortest lengths of stay compared to other facilities; welfare facilities had smaller capacities and were less filled to capacity;

justice-oriented agencies (i.e., police, courts, and corrections);

- Florida had a somewhat higher percentage of its children placed in care by families and Wisconsin a higher percentage placed by social service agencies than did the other states; and

- the majority of children leaving residential care were released to their families. Florida facilities had higher rates of release to families than did the other two states. Across states, facilities in the justice stream released children to their families at a higher rate than did those in the welfare or health streams.

FINANCING OF RESIDENTIAL CARE: PRIMARILY PUBLIC

Public funds were the primary direct source of support for residential care for children. GAO found this was consistently true in all three states, all three streams of care, and both public and private facilities. Looking at all facilities, even those privately operated, the majority received over 80 percent of their funds from public sources. Other findings included the following:

- In Florida, charitable contributions were more likely to support large shares of facility budgets than in New Jersey or Wisconsin. A related finding was that very high levels of public funding were less prevalent in Florida than in the other states;

- Higher levels of private (e.g., parent or health insurance) payments were most prevalent in the health stream, and higher levels of charitable contributions were most prevalent in the welfare stream;

- New Jersey and Florida had the highest and lowest per capita median daily costs for care, $63 and $40, respectively;

- Within streams of care, health-oriented facilities had the highest daily costs ($65) and welfare facilities the lowest ($40); and

- Costs differed little between publicly and privately operated facilities ($50 and $46 per day, respectively).

THE CHILDREN: MALES, ADOLESCENTS PREDOMINATE

GAO examined the population of children in residential care in terms of absolute numbers, race, age, sex, and income level of family. Each factor was then investigated for each of the three dimensions of interest: state, stream of care, and facility auspice. To summarize the characteristics of the 10,549 children in responding facilities in the three states:

- Three-quarters of the children were male; two-thirds were white;
- Nearly half were between the ages of 12 and 15;
- More than half were in Florida facilities;
- Two-thirds had families with annual incomes of less than $15,000;
- Except for Wisconsin, most placements for males were into the justice stream. In Wisconsin, the welfare stream was most often the place of care for males;
- Nonwhite children were placed in residential care at higher rates than white children, relative to their proportions of state populations. This was true in all three states;
- For all three states combined, the majority of residents in justice facilities were nonwhite. Wisconsin, however, had fewer nonwhites in the justice stream than in either the welfare or health stream;
- In each state, over 70 percent of residents in health facilities were white;
- Except for Wisconsin, nonwhite children were placed more often in public facilities than private. In New Jersey and Florida, approximately two-thirds of all nonwhite children placed were in public facilities; white children were more often placed in private facilities; and

- In a sample of children placed by state and county agencies, significantly higher percentages of whites went to private facilities and nonwhites to public facilities (pp. 64-66).

GOVERNMENTAL OR NONGOVERNMENTAL PLACEMENT? ASSOCIATED FACTORS

Whether children were placed in care through governmental or nongovernmental processes was strongly associated with certain factors, GAO found. For instance: children whose placements involved a state or local public agency more often had criminal or status-offense histories, had had prior residential experiences, were victims of abuse, had been considered violent, or were Medicaid-eligible. On the other hand, children whose families had medical insurance available to them were more frequently placed via a nongovernmental process.

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ABBREVIATIONS

CRC	Case review committee
CST	Child study team
CYFS	State division of youth and family services
GAO	U.S. General Accounting Office
PODSE	Program Operations and Delivery of Services Examination

CHAPTER 1

INTRODUCTION

In 1838, the supreme court justices of the State of Pennsylvania issued a decision that had significant implications for the role played by government in the relationship between parent and child. The case involved an appeal by a Mr. Crouse on behalf of his daughter, Mary Ann, who had been interned in the Philadelphia House of Refuge. Mr. Crouse argued that his daughter had been denied the right to trial by jury and had, therefore, been illegally detained. In their decision, the justices ruled against Mr. Crouse, holding that, for his daughter, the Philadelphia institution was a school, not a place of incarceration. This decision introduced the doctrine of parens patriae or "guardianship by the community" into the American legal system. Significantly, it was also an instance in which the state played a role in removing a child from her home environment.

This report is concerned with characterizing the children[1] in residential care settings, the process by which they are placed there, and the attributes of facilities that serve them. It is directed at answering four general questions:

1. What is the profile of existing residential care facilities (e.g., public and private inpatient mental health treatment programs, inpatient chemical dependency programs, group foster homes, juvenile correctional facilities)?

2. What are the sources of the funds used to support these facilities (e.g., private payments, state or federal funds, third-party payments)?

3. What are the characteristics of the populations served at these facilities?

4. What factors influence the placement of juveniles in each type of facility?

The U.S. General Accounting Office (GAO) undertook the study at the request of Representative Miller of California (see appendix I for his letter of request).

HISTORICAL INSTITUTIONS PARALLEL TODAY'S CARE FACILITIES

Before discussing our findings on residential care for children, a brief conceptual overview of its development in this country is appropriate. According to one writer, "By the 18th Century the seeds of the modern concept of childhood had become firmly rooted: children were described as fragile, innocent and sacred on one hand, but corruptible, trying and arrogant on the other."[2] These seeds grew into the 20th Century belief that "the ideal child should be submissive to authority, obedient, hard working, a good student, sober, chaste, circumspect in habit, language and associates and should otherwise avoid the appearance of evil . . ."[3]

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[1] Although this report is concerned with children and youth, the term "children" will be used throughout to represent both and to mean individuals from birth to and including age 18.

Although perhaps an oversimplification, there is considerable truth to the assumption that today's population of children perceived as needing residential care is comprised of individuals who violate the above-mentioned characteristics of the "ideal child." Such violations may flow from many sources and come in many forms, including criminality, mental retardation, out-of-wedlock pregnancies, emotional disturbance, drug use, and truancy, to name but a few.

Historically there have been three major forms of residential care for children--the asylum, the house of refuge or orphanage, and the reformatory. Although the terms may bring to mind images of squalor and deprivation, it is important to recognize that these institutions were intended to save children.

Today, although the terminology has changed, the principal forms of current residential care closely parallel these 19th Century institutions in both populations served, objectives and categories of care (which we term in this report "streams of care" and define further in chapter 2).

But it is important to note that the similarities between current and previous residential care institutions (delineated in table 1) should not be taken as evidence that no significant changes have taken place. One change has been in treatment perspectives. Institutions no longer consider corporal punishment an appropriate treatment option. Other changes between past and present include the following: private sector involvement in residential care has grown; emphasis on placing younger children in residential facilities has decreased; the number of voluntary commitments has increased; the authority of the juvenile court has expanded; and a mental health perspective has been established in the treatment of children.

By the mid-1960s, there began a major reform movement involving, among other elements, a decreased emphasis on removing children from their homes, assurance of due process for children, and decriminalization of status offenses. By the mid-1970's, these

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[2] Empey, LaMar T. "Detention, Discretion, and History," Journal of Research in Crime and Delinquency, 14:2 (July 1977), pp. 174-76.

[3] Empey, 1977.

Table 1

Comparison of Residential Care Institutions: Historical and Current

Historical institution	Comparable current institutions	Population served	Objectives	Stream of care
Asylum	Psychiatric hospital; Home for developmentally disabled and retarded; Substance abuse program; Home for emotionally disturbed	Children with internal problems, either physical or mental	Diagnosis; Treatment; Maintenance (for chronically ill)	Health
House of refuge or orphanage	Home for dependent and neglected children; Shelter for abused children	Children whose home environment is deemed inappropriate	Provide surrogate home environment	Welfare
Reformatory	Jail; Prison; Training school; Detention facility; Status offender program	Children whose behaviors violate legal or moral standards	Punish and thereby deter; Remove from society and thereby prevent further behaviors; Rehabilitate	Justice

reforms had been incorporated into several pieces of federal legislation directed at improving the quality of residential services for children.

One impact of this reform movement has been a considerable population shift from facilities caring for dependent and delinquent children to those providing other forms of care, as table 1 and (on the following page) table 2 show. Between 1966 and 1981, there was a 59 percent decrease in the absolute number of children in the former kind of facility (table 2). More striking is the

Table 2

Number of Children in Residential Care by Type of Facility and Change in Number, 1966 and 1981

Facility type	1966	1981	Change
Temporary shelter	1,832	3,933	+2,101
Detention care	10,875	16,075	+5,200
Care of dependent and neglected	60,459	24,712	-35,747
Care of delinquent or predelinquent	55,000	48,740	-6,260
Care of emotionally disturbed	13,876	21,011	+7,135
Psychiatric care of mentally ill or emotionally disturbed	8,028	13,484	+5,456
Care of drug or alcohol problems	--	1,806	+1,806
Care of pregnant adolescents	5,835	1,658	-4,177
Totals	155,905	131,419	-24,486

SOURCE: University of Chicago, School of Social Service Administration, The National Survey of Residential Group Care Facilities for Children and Youth: Some Preliminary Findings (April 1983).

data in table 3 showing that, while the proportion of residents in facilities for dependent and neglected children decreased 55 percent, in all other facilities it increased or remained stable. These data make it clear that the latter half of the 1960's and the decade of the 1970's saw a strong shift from a "child welfare" orientation to other forms of residential care.

OBJECTIVES, SCOPE, AND METHODOLOGY

Federal involvement in residential care for children in recent years has manifested itself through financial support and judicial decisions as well as legislation. Among the federal programs which relate to children in residential care are foster care funding (Title IV-E of the Social Security Act), child-welfare services (Title IV-B), social services block grants (Title XX),

Table 3

Prevalence of Residential Placement in the Child Population, 1966 and 1981

Facility type	No. per 100,000 children in total population 1966	 1981
Temporary shelter	3	6
Detention care	15	25
Care of dependent and neglected	86	39
Care of delinquent or predelinquent	78	77
Care of emotionally disturbed	20	33
Psychiatric care of mentally ill or emotionally disturbed	11	21
Care of drug or alcohol problems	NA	3
Care of pregnant adolescents	8	3
Totals	221	208

SOURCE: University of Chicago, School of Social Service Administration, The National Survey of Residential Group Care Facilities for Children and Youth: Some Preliminary Findings (April 1983).

and child nutrition programs (Child Nutrition Act of 1966, as amended).

Despite this significant federal role, residential care remains primarily a state responsibility, and the states vary considerably in their approaches to it. Thus, we decided to conduct our examination of such care at the state level. Available resources limited the number of states studied to three.

Choosing the states was a joint effort by GAO and congressional staff. First we constructed 12 "packages" of three states each. These packages were developed using data from a University of Chicago study of residential facilities.[4] Each of the packages included a brief statement that explained the logic underlying its construction. For example, one package had three states that varied in the size of their residential care systems, while another combined three states that all had an emphasis on justice-related facilities. Congressional staff made the final selection, choosing the package containing Florida, New Jersey, and Wisconsin. These three states all had between one- and two-hundred facilities, were located in different geographical regions, and varied in the extent to which the residential care function was centralized.

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[4] University of Chicago, School of Social Service Administration, The National Survey of Residential Group Care Facilities for Children and Youth: Some Preliminary Findings (Chicago: April 1983).

In adopting this method of site selection, our intent was to maximize the number of critical issues that could be addressed with available resources. On the other hand, the subjective nature of the selection process and relatively small number of states chosen mean our findings are not generalizable to the national level.

A judgmental, nongeneralizable sample is a common element in the design that we adopted for this study, the Program Operations and Delivery of Services Examination (PODSE).[5] An approach developed by us, PODSE is intended to provide decision makers with a "snapshot" of how programs are operating. The design is flexible and allows its users to structure data collection and analysis plans to address the specific evaluation issues with which they are concerned. Its primary limitation, aside from nongeneralizability, is that it describes its subject matter at a single point in time and does not give any indication of significant trends.

In our case, data collection plans were driven primarily by the four questions we set out to answer. We addressed the first three (on profiles, funding, and population characteristics of existing facilities) by a mail survey. It covered all residential care facilities that provided services to children in our three study states. Responses were received from 88 percent of those receiving our questionnaire. Of those responding, 478 facilities were qualified to be included in our sample. This high response rate means that the primarily descriptive findings resulting from our data analysis are generalizable to each of the three states. (See appendices II and III for the questionnaire and technical discussion on how the survey was conducted.)

To answer the fourth question, on factors influencing placement, we decided to select a sample of children in residential care and collect information that would allow us to reconstruct how they got there. We would have liked to collect data through observation of the placement process in operation, but this was not possible. As we make clear in chapter 4, there is not one

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[5] GAO, Institute for Program Evaluation, An Evaluative Approach to the Examination of Program Operations and Service Delivery: PODSE, Exposure Draft, Methodology Transfer Paper 2 (Washington, D.C.: April 1983).

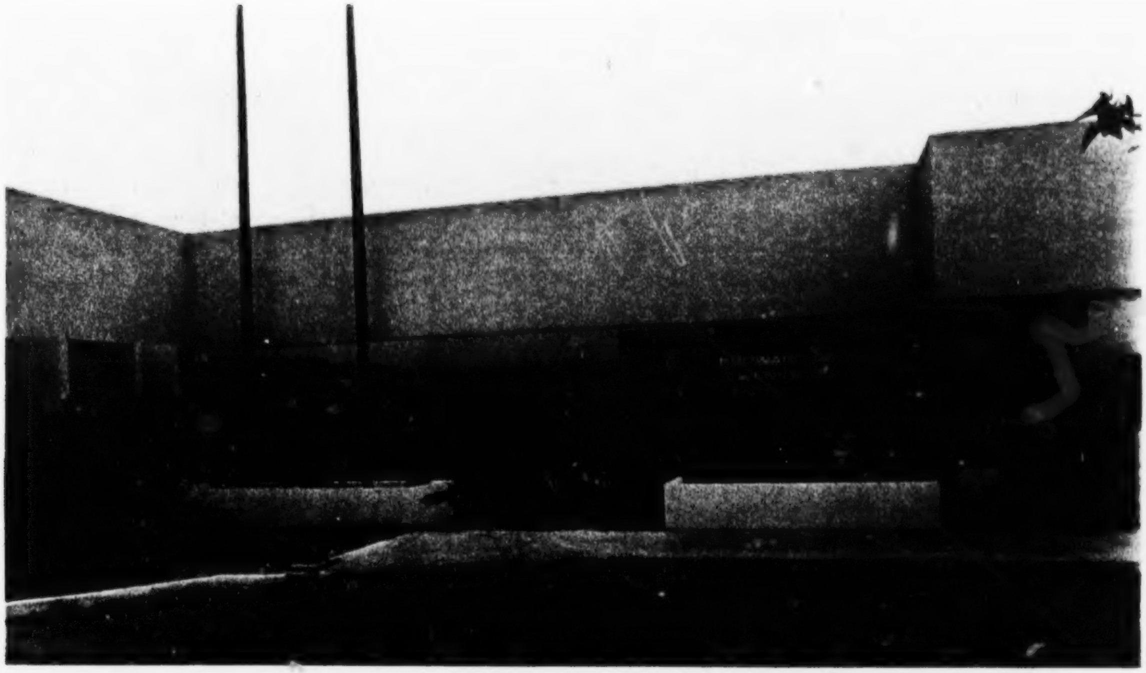

Photo courtesy of Florida Department of Health and Rehabilitative Services

A public institution in the justice stream of care, this juvenile detention center on Florida's lower east coast is one of the 478 facilities (195 of them in Florida) included in GAO's study.

placement process, but many. Furthermore, these processes are often complex, the decision points numerous, and many decision points (e.g., an informal meeting between a private physician and a child's parents) do not lend themselves easily to observation by outsiders.

The approach we selected had two limitations: 1) because we looked only at a population actually in a residential care setting, we could reach no conclusions about the major decision in any placement process, i.e., whether an out-of-home placement should have been made; and 2) our results allowed us only to say what factors were associated with different types of placements, not the extent to which the factors actually influence placement.

The need to reconstruct placement processes for children required individual-level data. These were collected from the case records of 539 children in residential care during September and October of 1983. Appendix IV describes in detail how the case records were chosen and information gathered for each child. As the selection of case records could not be conducted in a truly random manner, the findings are not generalizable to the state or national levels.

Our report differs from much of the previous work on residential care for children in one important aspect. Unlike earlier work, we adopted a comprehensive approach. That is, we did not restrict our investigation to one subpopulation of residential care children (e.g., abused, delinquent, autistic, etc.) or one type of facility (e.g., detention center, shelter, group home, etc.). This approach, which drove our design choices, has the advantage of allowing comparisons that can be expected to deepen the general understanding of important issues relevant to children in out-of-home settings. The breadth of the study, however, presented two major disadvantages:

1. Our definition of residential care facilities was necessarily general. For example, in the course of site visits to collect information on facility residents, the first stop in one state was at a 1400-acre boys' ranch. We spent the day at this rural facility, which housed more than 100 children, accepted only children who had never been convicted of a felony, advertised for clients on television, and taught children to milk cows, ride horses, fix cars, and bale hay.

The following morning, we found ourselves at an urban group-home that housed eight children, all of whom had had multiple experiences with the criminal justice system and had been placed by a state agency. Many of them, according to the home director, were there as their "last stop" before leaving the child care system at 18. The contrast between these two environments was somewhat disturbing; as different as they were, both fit our description of "residential facilities."

We have tried to include all out-of-home environments in our study. But this approach is only a necessary first step. Subsequent studies will need to further refine the distinctions between different categories of residential care into specific subsets that are more sensitive to differences existing within the categories. Our effort, however, should help to increase the general understanding of what these subsets might be.

2. We had to omit specific pieces of information that might well have been important. For example, in talking with a state official in New Jersey, we asked, "How is the actual facility selected, once a decision is made that the child should be placed?" His response: Some caseworkers target their efforts to the one or two facilities that seem most appropriate, while others adopt a "shotgun" approach. They mail out the child's records to a large number of facilities and make the placement in the first facility that accepts the child. Although we viewed as important the differences between these two strategies, the breadth of our investigation prohibited us from getting to the level of specificity at which variations in individual behaviors could be presented.

* * *

Copies of the report were sent to state/county officials in our three study states for their review. (Their comments are contained in appendix V.) The decision to send the report for state rather than federal agency review was based on the fact that the focus of the study, the placement decision, is a responsibilty of states. Federal agencies do not have authority or responsibility for making placement decisions.

PROFILE OF THREE STATES: SOME BACKGROUND

Some background information on our three study states may help the reader to place them in context and appreciate their similarities and differences in philosophy and practice with respect to residential care for children (population figures cited are from the 1980 census[6]):

- Florida - One of the fastest growing of all states, Florida was the largest of our three study states in total population,

Public services to Florida's diverse population, with its many cultural differences and social needs, are supported by a state sales tax. These three youngsters are in shelter care in Broward County.

Photo courtesy of Florida Department of Health and Rehabilitative Services

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[6] U.S. Bureau of the Census. 1980 Census of Population, Characteristics of the Population, vol. 1 (Washington, D.C.: 1982).

number of families, and number of children 18 years of age or younger. (In terms of their percent of the total population, however, Florida had the smallest percentage of children 18 or younger--26 percent.) In 1980, Florida closely approximated New Jersey's percentage of its population residing in urban areas (84 and 89 percent, respectively), but because of its geographic size, it had a relatively low density (166 people per square mile) compared to New Jersey. Florida attained statehood in 1845. It experienced a number of net population gains through migration--predominantly by white residents of northern states from the 1920s to the 1950s--and, in more recent years, by individuals from Cuba, Haiti, Nicaragua, and Colombia. This diverse group combines with those who consider themselves native Floridians to form a state population with much cultural variety and many social needs. Additionally, the state must concern itself with providing services to a large number of retirees located predominantly in southern Florida and many families in northern and central Florida. These services are supported in large measure by revenues obtained from sales taxes; Florida has no income tax.

- New Jersey - The second largest of our three states, New Jersey was the most densely populated (940 people per square mile). People 18 years old or younger accounted for 29 percent of its population in 1980. In addition to being the most highly urbanized state, New Jersey is adjacent to two major population centers, New York City and Philadelphia, which influence the New Jersey counties near them. Being urbanized and the oldest of the three states (it entered the Union in 1787), New Jersey experiences more intensely the problems of shrinking tax bases and provision of social services often associated with older, industrial areas. During the first half of the 20th century, political machines controlled the urban centers in the northern part of New Jersey. In the middle and latter part of the 1970s, changes were effected to correct abuses in the political process. The 1970s also saw the implementation of a personal income tax.

- Wisconsin - The smallest of our three states in absolute population, Wisconsin was also distinguished in 1980 by having the highest percentage (31) of children 18 years of age or younger and the smallest proportion of nonwhite children (8 percent). (In Florida and New Jersey, slightly less than a quarter of children were nonwhite.) Wisconsin was the least densely populated and urbanized state of the three: 84 people per square mile and 64 percent urban. Having achieved statehood in 1848, Wisconsin was among the first of the states to experiment in social and economic affairs. The "Wisconsin Idea," a philosophy of government introduced in the early 1900s and credited to Robert LaFollette and the Progressive Party, set a national pattern for progressive legislation, including minimum wage and workers' compensation laws.

REPORT OVERVIEW

We begin the report with descriptions in chapters 2 and 3, respectively, of residential care facilities and the population of children in those facilities. Most of the information in these chapters is drawn from our survey of facilities in Florida, New Jersey, and Wisconsin. Where appropriate, however, we present national-level data from the 1981 University of Chicago survey, for purposes of comparison.

Chapter 4 explains generally how placements are made to residential facilities and describes how the three states exhibited considerable similarities in philosophy as well as differences in practice. The chapter's concluding section introduces the concept of nongovernmental placement (made without the formal or informal involvement of state or county officials).

The decision to place a child in residential care is the focus of chapter 5. We present our findings on a variety of factors associated with two types of placement in the three states. The chapter concludes with an examination of the relationship between a child's race and placement in a public or private facility. The final chapter summarizes our findings.

CHAPTER 2

PROFILE OF RESIDENTIAL CARE FACILITIES

This chapter addresses two of the questions posed to us concerning patterns of placement of children and youth in residential care facilities: What are the range, types, and characteristics of available residential child care facilities, and what are their sources of funds?

We first provide a descriptive overview of the residential facilities that serve children and youth in Florida, New Jersey, and Wisconsin. Statistics on the number, types, auspice, and size of existing child care facilities are presented. Also, we characterize the sources of facility referrals, durations of stay in residential care, and places to which facilities release their residents following care.

Finally, we describe some financial aspects of residential care, including cost of care and types of funds that comprise facility budgets. The information on facility characteristics is then summarized and discussed in terms of major consistencies and variations among the different categories of facilities.

To facilitate understanding of the findings, our analysis groups our results by three dimensions of interest, each with several subgroups or categories, as follows:

- States--Florida, New Jersey, and Wisconsin,
- Streams of care--Mixed welfare, justice, and mixed health, and
- Auspices--Private and public.

The criteria by which we classify facilities into one stream of care or another are presented in table 4. We grouped facilities according to their responses to our questions concerning their primary and secondary objectives (questions 14 and 15 of our questionnaire--see appendix III). Thus, the resulting typology is less concerned with what facilities are called than with the types of populations they serve, and, as one reviewer of the report suggests (see appendix V), it is possible that we placed some facilities in categories other than those their official designations might suggest. In addition, although the table refers to "mixed welfare" and "mixed health," for brevity we use the terms welfare and health in the balance of the report.

NUMBER OF FACILITIES VARIED BY STATE, STREAM OF CARE, AND AUSPICE

Florida's 195 residential child care facilities constituted the largest number in our three-state sample, followed by

Table 4

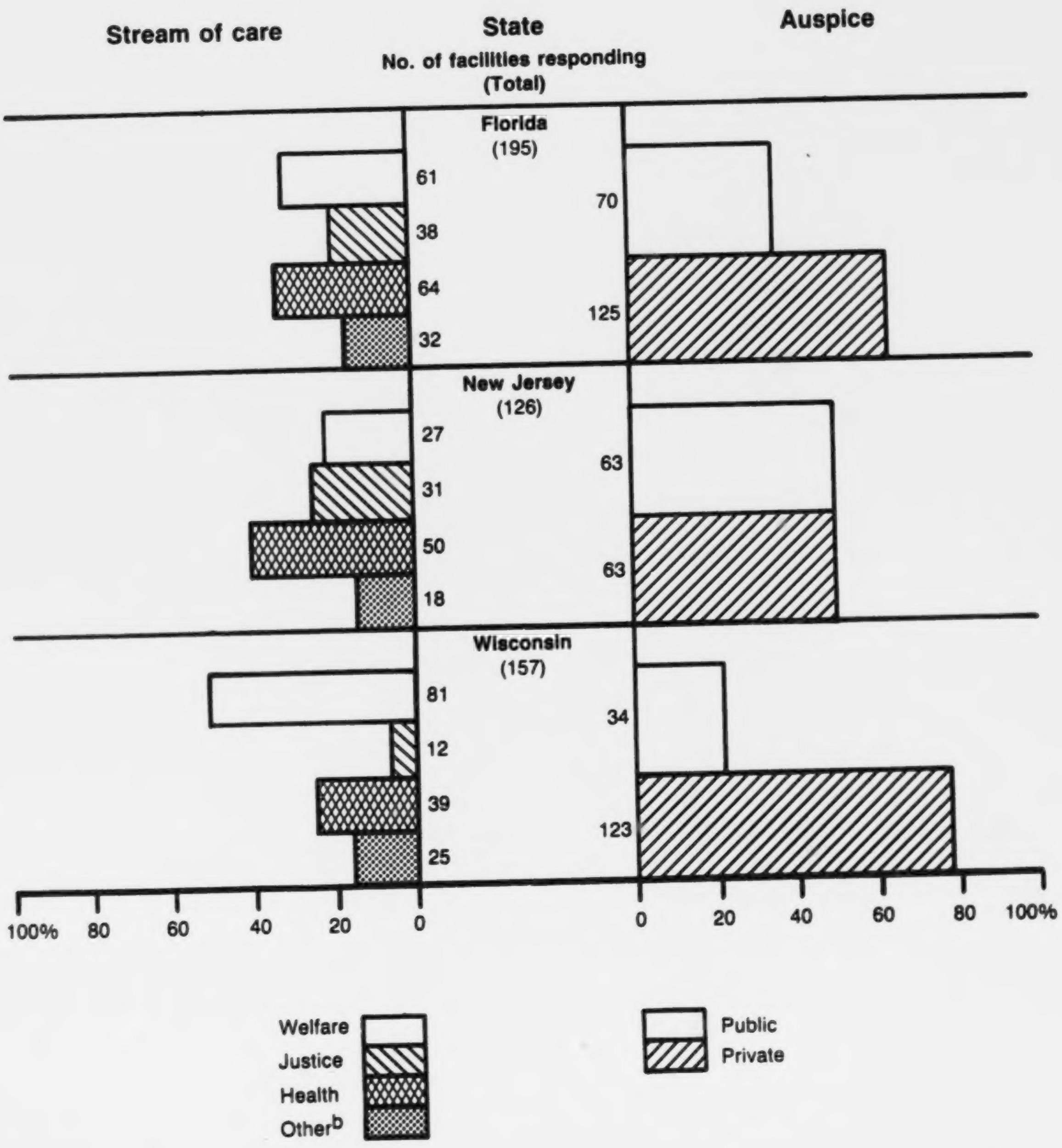
Criteria Used to Classify Facilities by Streams of Care

Stream of care[a]	Objective of facility	
	Primary	Secondary
Mixed welfare	Care of dependent, neglected, and abused, children	Care of status offenders, delinquents, and substance abusers
Justice	Detention of children and care of status offenders, delinquents, and juveniles in need of supervision	None
Mixed health	Diagnosis, testing, or evaluation of children; care, treatment, training, or education of substance abusers, mentally ill, emotionally disturbed, mentally retarded, developmentally disabled, or physically handicapped	Care of dependent neglected, abused, or delinquent children

[a] Seventy-five facilities (16 percent of the total) could not be classified into a stream of care. They included: (1) facilities for which data were missing, (2) facilities that provided a boarding school education to children with special problems, (3) facilities that cared for other special types of populations (e.g., pregnant adolescents), or (4) individual homes for foster children. (While data were collected on group foster care facilities, individual foster families were not included in the universe.)

Figure 1

Distribution of Facilities within States by Stream of Care and Facility Auspice[a]



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[a] Numbers within bars represent percentages of facilities responding in state.

[b] Includes facilities not classifiable into a stream or with missing data.

Wisconsin's 157 and New Jersey's 126 facilities.[1] As figure 1 shows, the highest percentage of Florida facilities were in the welfare and health streams (31 and 33 percent, respectively); a plurality of New Jersey facilities were in the health stream (40 percent); and a majority of Wisconsin facilities were in the welfare stream (52 percent). Wisconsin had a smaller proportion of facilities in the justice stream (8 percent) than either Florida (19 percent) or New Jersey (25 percent).

The breakdown by auspice in each state (figure 1) shows that New Jersey had the highest percentage of publicly operated residential child care facilities (50 percent), and Wisconsin had the smallest percentage (22 percent). Florida fell in between with 36 percent of its 195 facilities public.

Among the 403 stream-classifiable facilities, 169 (42 percent) were in the welfare stream, 81 (20 percent) in the justice stream, and 153 (38 percent) in the health stream (see figure 2 on page 16). As might be expected, there was a substantially higher proportion of privately operated facilities in the welfare and health streams than in the justice stream. Roughly three-fourths of facilities in both the welfare and health streams, but only 16 percent of justice facilities were privately operated. These results are understandable, considering that the juvenile justice system is public, involving police departments, courts, probation departments, and correctional facilities.

SIZE OF FACILITIES COMPARED WITH OCCUPANCY RATES

We compared the size (capacity) of residential care facilities with their occupancy rates (average daily census) according to the three variables: state, stream of care, and auspice (see figure 3 on page 18).

Florida had the largest median[2] facility capacity, followed by New Jersey, then Wisconsin. In addition to having the smallest

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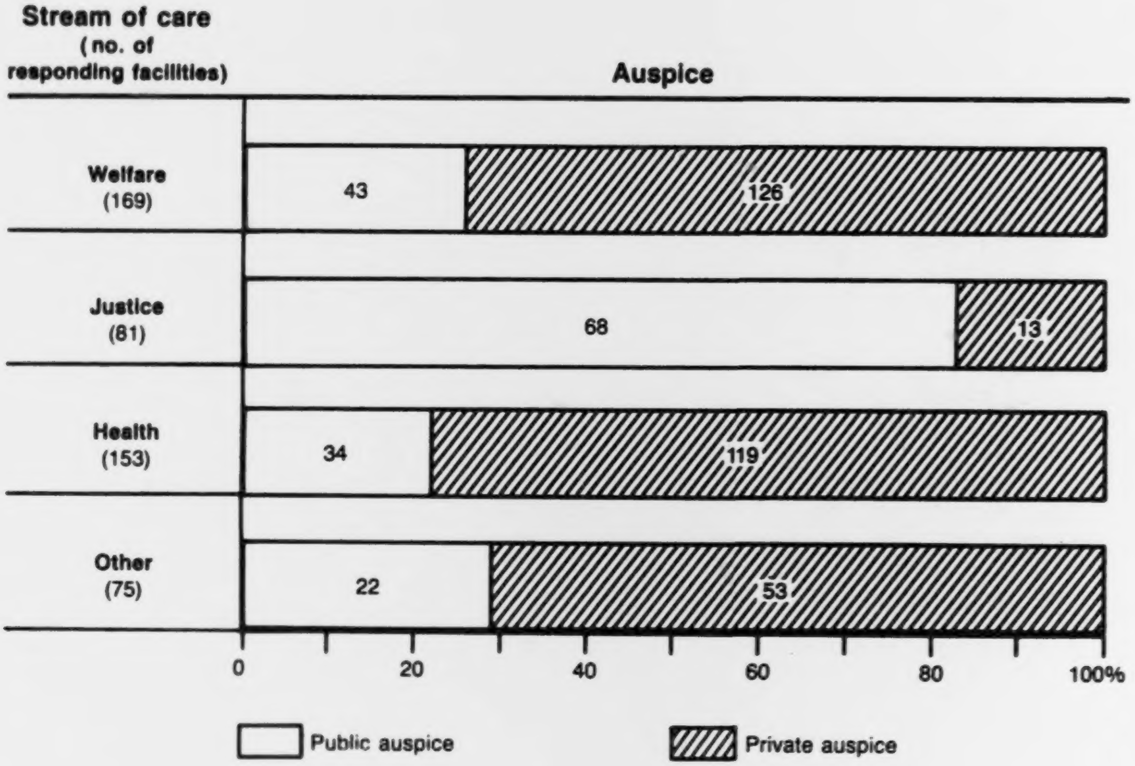
[1] Of the three-state total of 478 facilities, 353 served only children (i.e., up to 18 years of age) and 124 served both children and adults (one facility did not report this information). When describing facility characteristics in this chapter, we refer to the total sample of 478 facilities. Where data from child-only facilities or the child portion of mixed facilities yield a more valid or accurate description of facility characteristics and practices, we exclude mixed facility data from the analysis and note it accordingly.

[2] The distribution of facility sizes and average child populations in facilities are skewed by the presence of a relatively small number of very large facilities. With such skewed distributions, the median is a better measure of central tendency than the mean.

Figure 2

Distribution of Facilities Within Stream of Care by Facility Auspice across Study States (Florida, New Jersey, and Wisconsin)[a]



[a] Numbers within bars represent numbers of facilities responding; length of bars is based on percentage of facilities.

facilities, Wisconsin had a smaller percent of its facilities filled to capacity (75 percent) than did the other two states. Wisconsin's smaller facility size was understandable, given that 78 percent of its residential facilities were private (see figure 1) and overall, private facilities were smaller than public. The data suggest that private auspice of care and smaller facility size may be correlates of one another.

Facilities in the welfare stream were smaller, had a lower average daily census, and were less filled to capacity than were those in the other streams. We found health and justice facilities to be, respectively, 2 and 2.5 times as large as welfare facilities. Health and justice facilities were about 8 percent more filled to capacity.

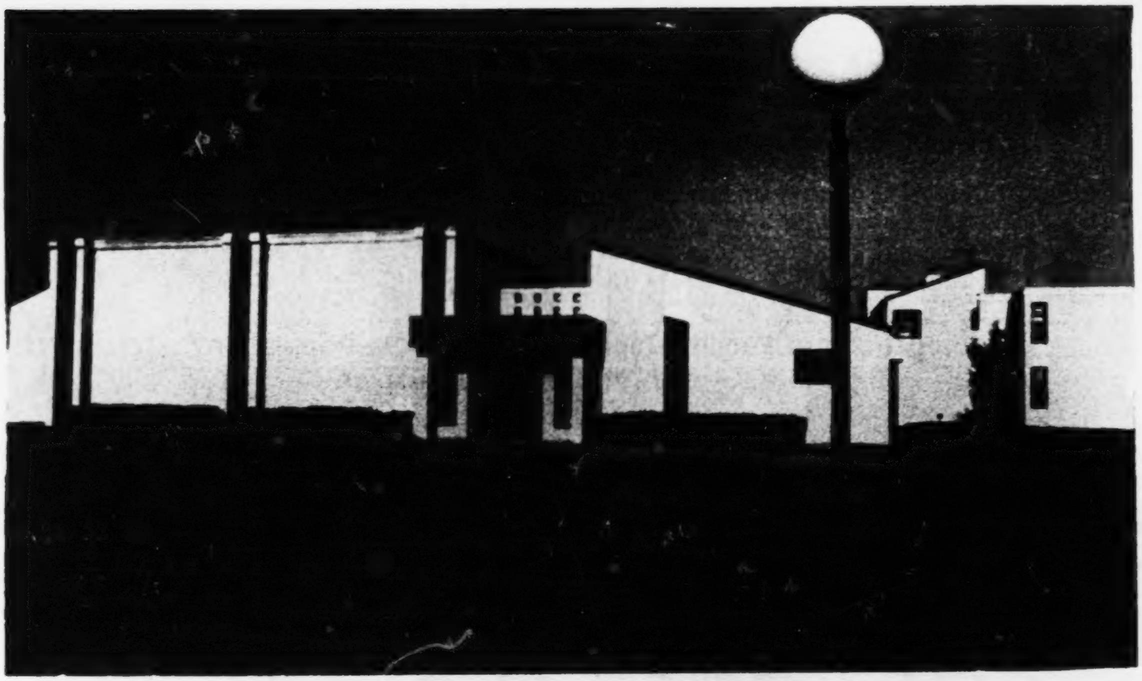


Photo courtesy of New Jersey Department of Human Services

Among GAO's three study states, New Jersey facilities occupied the middle range in terms of both capacity and actual child population. This facility, Ewing Residential Center for Adolescents near Trenton, is operated by the New Jersey Department of Human Services.

In a similar vein, the data revealed that public facilities had larger capacities and consequently a higher average daily census than private facilities. Interestingly, there was no difference in the occupancy rate of public versus private facilities: both were filled to 83 percent of capacity.

FLOW OF RESIDENTS THROUGH THE RESIDENTIAL CARE SYSTEM

Generally, a child may be referred to residential facilities for care by the family, a social service agency, a health/medical source, or the justice system. In our facility survey, we gathered data on the prevalence of these four referral agents[3] in the placement process, and examined how they differed by state, stream of care, and average length of stay (see figure 4).

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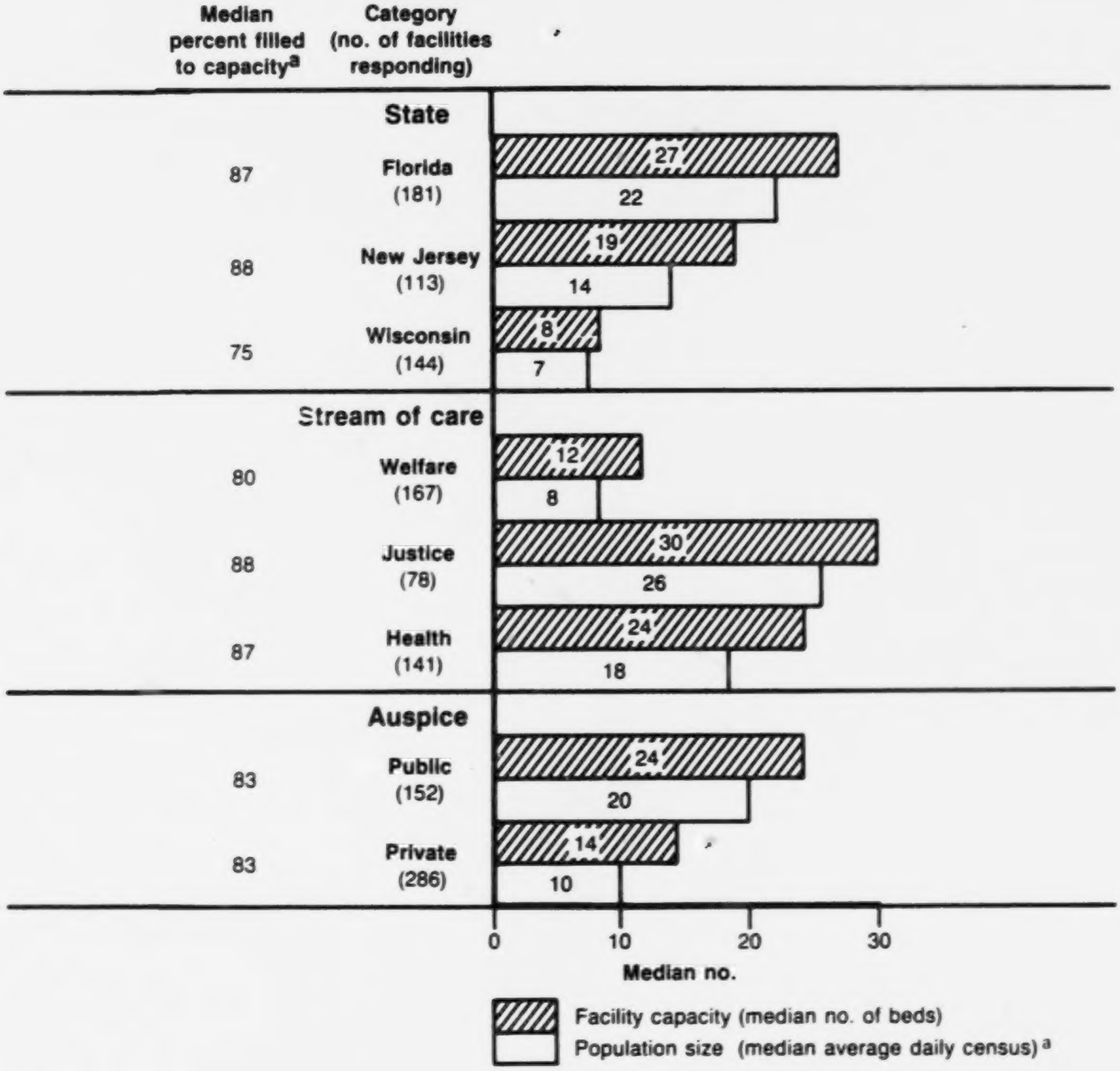
[3] We used family to include self, parent, guardian, or other family member; social service agency to include church-related or public/private social service agency; health/medical source to include private physician, psychiatrist, psychiatric mental health facility, or general health care facility; and justice system to include police department, court, probation department, or correctional facility.

For Florida and New Jersey, the referral source profiles were quite similar. Justice system personnel were the primary sources of referral in both states, followed by social service agencies,

Figure 3

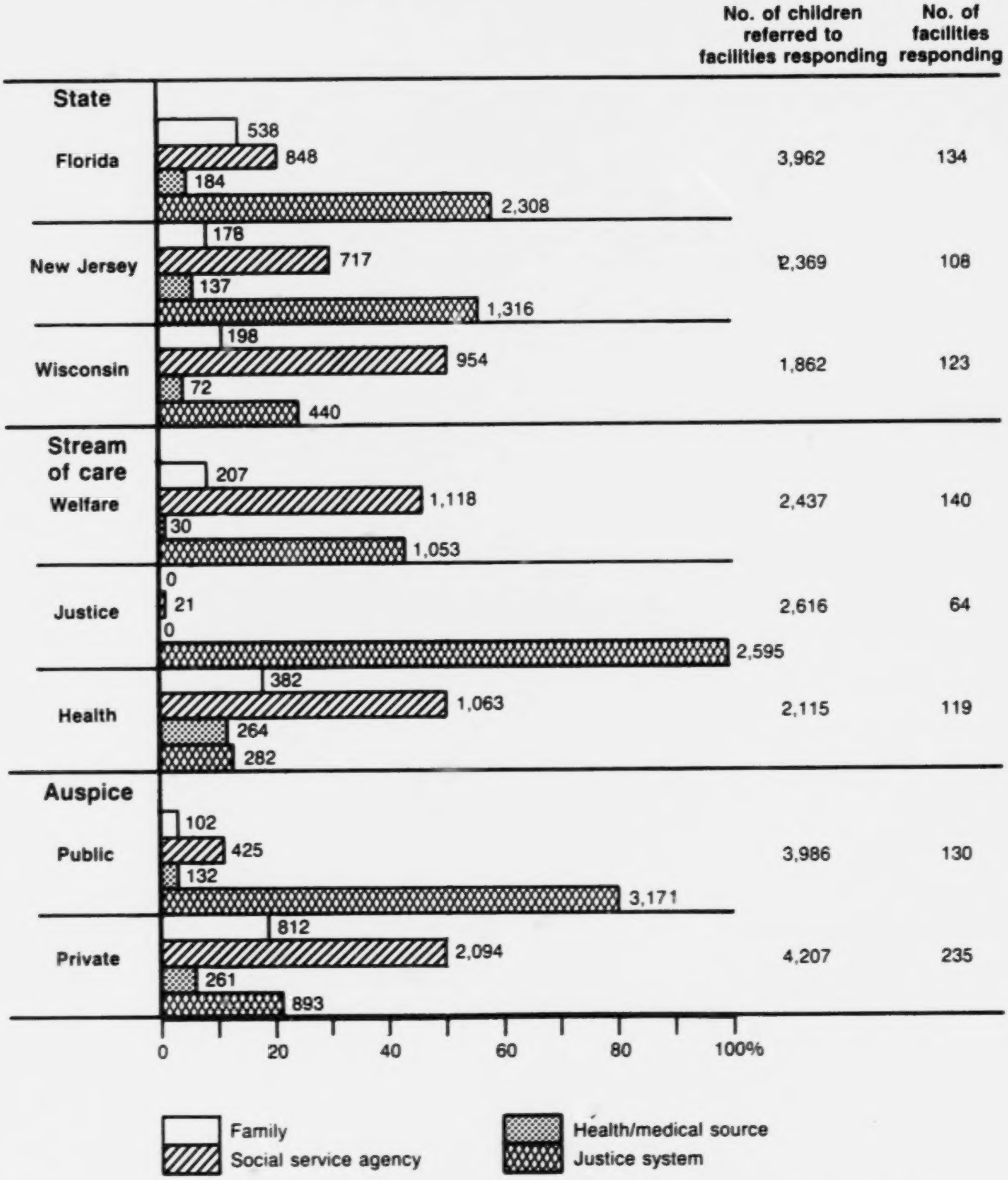
Comparison of Facility Capacity with Facility Population by State, Stream of Care, and Auspice



[a] (Average daily census/facility size) × 100. For each state, percentage is based on the distribution of the state's occupancy rates, a more sensitive measure than the point estimate obtainable by dividing median facility population by median facility size. Thus, New Jersey facilities are 88 percent filled to capacity, rather than 14/19 or 74 percent filled.

Figure 4

Sources of Referral to Residential Care by State, Stream of Care, and Facility Auspice[a]



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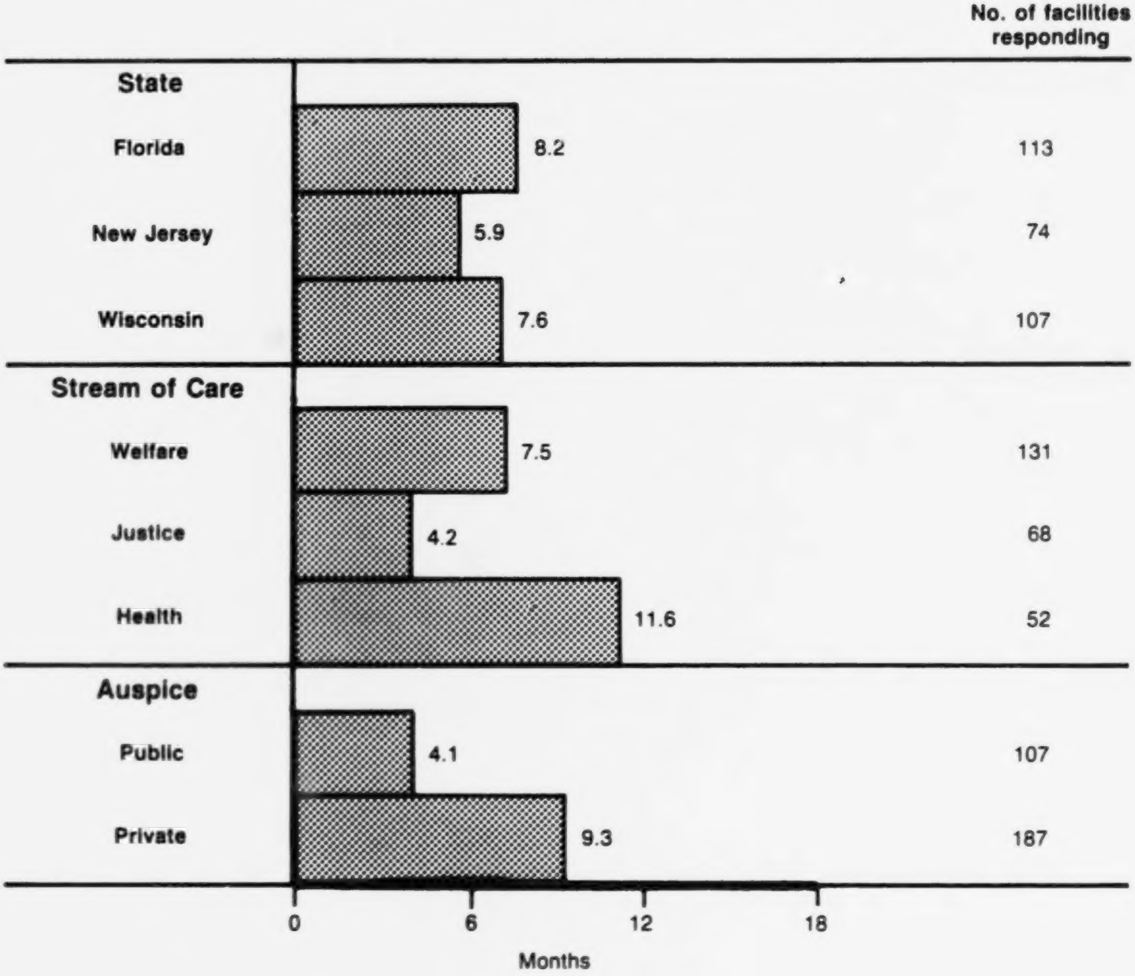
[a] Numbers adjacent to bars represent numbers of children referred to care by that source. Length of bars represents percent of children within group. Numbers and percents may not sum to 100, because some children were referred to care by other sources, including schools, education departments, other residential care facilities, etc.

Figure 5

Average Length of Stay[a] in Residential Facilities Serving Children Only by State, Stream of Care, and Auspice



[a] Computed using the following formula:

$$\frac{\Sigma\left(\begin{array}{l}\text{Median length of stay}\\ \text{in each category}\end{array} \times \begin{array}{l}\text{No. of children released}\\ \text{in each stay category}\end{array}\right)}{\begin{array}{l}\text{Total no. of children released}\\ \text{during last reporting period}\end{array}}$$

family, and health/medical sources. In Wisconsin, by contrast, the relative prevalence of justice system vs. social service agency referrals was switched: the proportion of referrals made by the justice system (24 percent) was less than half that of social service agencies (51 percent).

The predominance of justice system referrals was also noted in the justice stream and among public facilities, accounting for, respectively, 99 percent and 80 percent of referrals to residential care. Social service agencies, on the other hand, were the primary referral agents in the welfare and health streams, as well as in privately-operated facilities. Families do not refer children to residential care at very high rates. The highest rates (all nonetheless under 20 percent) were in Florida, the health stream, and private facilities.

Looking at the average length of time children stayed in a facility, we found differences in both stream of care and auspice (see figure 5). Most notably, the average length of stay in a health-oriented facility was close to one year, almost three times longer than the stay in a justice facility. Stays in welfare facilities tended to fall in the middle range, with 7.5 months the average reported. These differences may be a function of the types of populations and problems served by the streams.

For example, residential health facilities, in the context of this study, care for children who are mentally ill, emotionally disturbed, mentally retarded, developmentally disabled, or physically handicapped. For such chronic psychological and physical problems, a brief treatment period may be insufficient.

Justice facilities, on the other hand, deal with discrete instances of behavior problems brought to the attention of justice system personnel. As already noted in figure 4, 99 percent of children in the justice stream were referred there by justice system personnel. Since the justice stream aims to address, rather than cure or heal, a specific manifestation of problem behavior, the duration of stay in it may be shorter.

This is borne out again with respect to auspice of care, as shown in figure 5. The average length of stay in a private facility is over twice as long as that in a public facility (9.3 months, compared with 4.1 months). Given that many more justice facilities are public than are either health or welfare facilities, the observed variance in length of stay by auspice may be explained by the differences in length of stay among streams of care discussed above.

Upon release from facilities, where do children go? The majority return to their families, whether biological or adoptive (see figure 6 on page 23). In Florida, over three-fourths of children were released to their families, a higher rate than the 62 percent in Wisconsin. Recalling that Florida also exhibited a higher family referral rate than the other states, one might speculate that these children were simply returned to that referral source. However, case-level data are not available in the study to verify this.

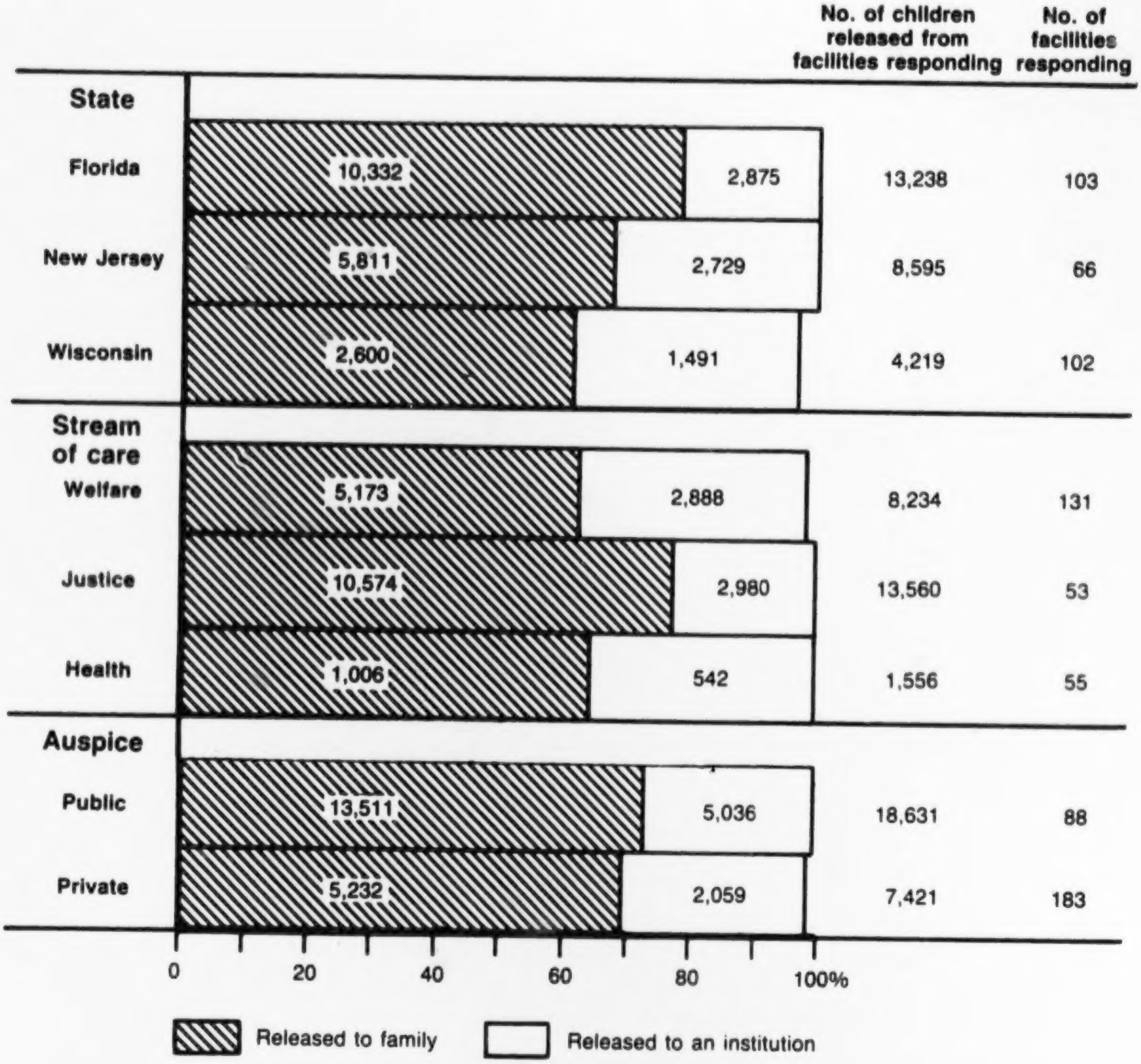
A higher percentage of children were released to institutions (i.e., public/private facility, foster family) in Wisconsin

Photo courtesy of New Jersey Department of Human Services

On average, children stay longer in health care than in welfare or justice facilities. This little girl is cared for at the North Jersey Developmental Center, a health facility in Totowa, New Jersey.

Figure 6

Distribution of Children to Families or Institutions by State, Stream of Care, and Facility Auspice[a]



[a] Numbers within bars represent numbers of children, length of bars represents percentages. Numbers and percentages do not sum to 100 because some children ran away or were released to living arrangements other than family or institution.

(35 percent) and New Jersey (32 percent) than in Florida (22 percent). Additionally, as figure 6 shows, over three-fourths of residents in the justice stream were released to family, compared with roughly two-thirds of residents in the welfare and health streams. Problems with the family environment are often a factor in removing the child from that environment, and dealing with physical or emotional problems is often beyond family capabilities.

Given this, it is not surprising that over one-third of children in the welfare and health streams did not go to their families upon release from a residential care facility.

PUBLIC FUNDING PREDOMINATED IN RESIDENTIAL CARE

What funding sources are used to support residential care?[4] This was Representative Miller's second question, and we analyzed our data on facilities to address it. Generally, we found public funding predominated, but private funds played a relatively greater role in the support of privately operated facilities.[5] Of 353 facilities that served only children, we received responses on daily cost of care from 313. The reported costs varied widely, from $5 to $600 per day. The median cost of providing residential care to a child ranged from $40 to over $60 per day (see figure 7).

In New Jersey, residential care was $12 and $23 more costly on a daily basis than care in Wisconsin and Florida, respectively. The $65 per day cost of care in the health stream was $24 and $17 higher than daily care in the welfare and justice streams, respectively. Also, median daily cost in private facilities was slightly lower than in public facilities.[6]

We examined three sources of funding for residential care:

- Public sources--State/local/federal governments, as well as public third-party insurance (e.g., CHAMPUS, Medicaid, Supplemental Security Income);
- Private sources--Payments for services by parents, private agencies, and private third-party insurance; and
- Charitable contributions--Private or corporate donors, funds from federated bodies (e.g., United Way), endowments, and investments.

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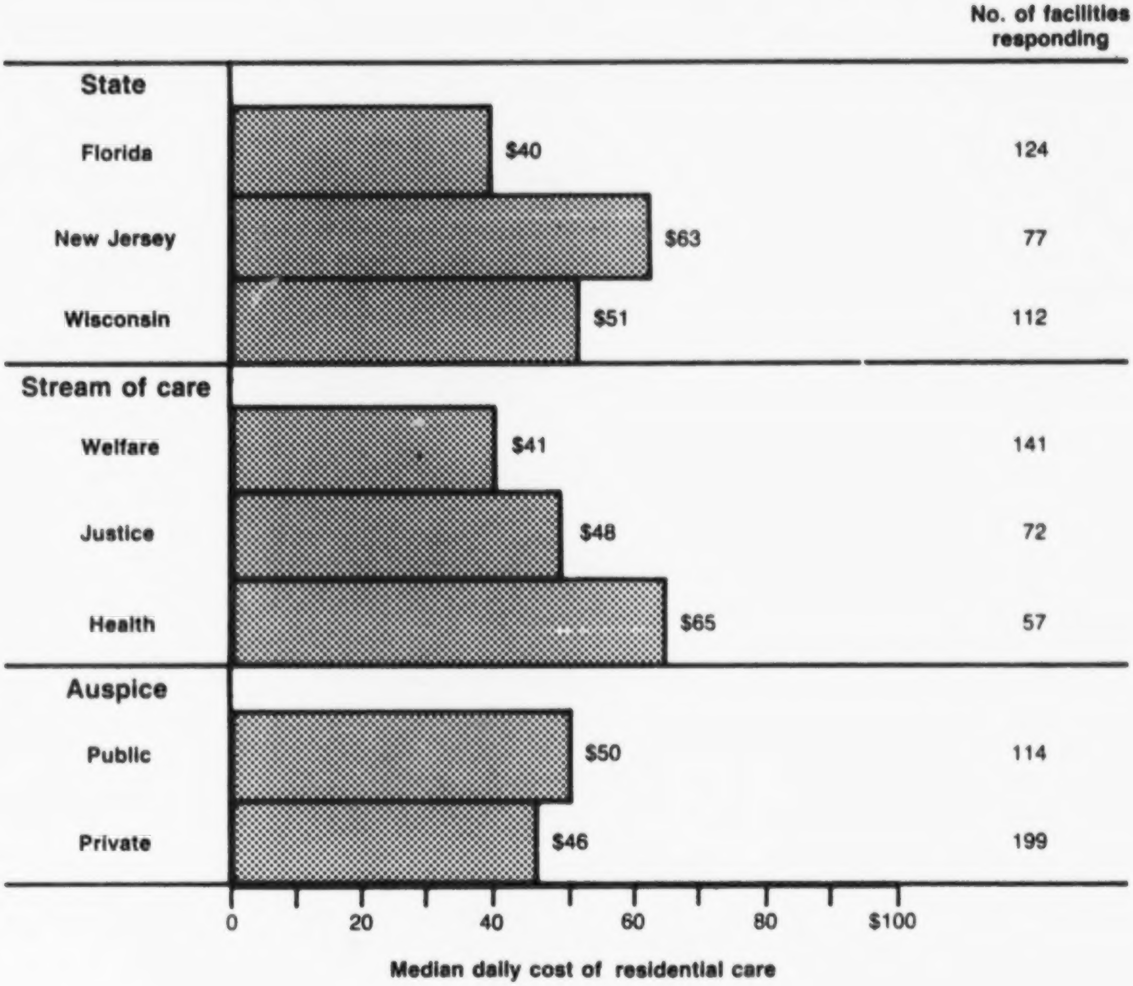
[4] A more complete treatment of funding sources will be contained in another report now being prepared for Representative Miller by GAO's Human Resources Division (GAO/HRD-85-62).

[5] We examined only direct sources of funds. So, for example, in Wisconsin, where the county assesses parents a monthly fee, collects it, and gives it to facilities, the funds would be categorized as public, even though they originated with the parents.

[6] GAO found some variations in its data on median daily cost that could increase the standard error of the estimated cost and cloud differences between categories of facilities. For example, some respondents reported only their facility's direct cost for care, while others included indirect costs as well. Additionally, some facilities incorporated the cost of public school education in their calculations of daily cost; others did not.

Figure 7

Median Daily Cost of Residential Care by State, Stream of Care, and Facility Auspice



Frequency tables depicting the distribution of funds associated with different funding sources constitute table 5 on the next page. In New Jersey and Wisconsin, public funds were a more substantial source of support for residential care than in Florida. In the former states, roughly three-fourths of the facilities had over 80 percent of their budgets comprised of public funds. In Florida, on the other hand, comparable levels of public funding occurred among only 51 percent of the state's facilities. Another contrast between Florida and the other states appeared in the percentage of facilities receiving high levels of charitable contributions. Eleven percent of Florida's residential facilities derived

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over three-fifths of their operating budgets from charitable sources, compared with only 2 percent in New Jersey and none in Wisconsin.

Yet, highly privatized Wisconsin (78 percent of facilities under private auspices) also had the highest proportion of facilities (77 percent) with the highest levels of public funding. Since private facilities may have contractual arrangements with public agencies for the placement of children, however, public funding for private facilities is not necessarily surprising.

The data in table 5 show that, regardless of whether sources of funds are examined by state, stream of care, or auspice, over 50 percent of facilities receive 80 to 100 percent of their budgets from public sources. With respect to stream of care, 52 percent of health-oriented facilities received more than 80 percent of their financial support from public funds, while this was true for 69 percent of welfare facilities and 96 percent of justice facilities.

Table 5

Sources of Funds for Residential Facilities by State, Stream of Care, and Auspice

Percentage of facility's budget	Sources of funds [Number of facilities (percentage of number reporting[a])]								
	Public No. (%)	Private No. (%)	Charity No. (%)	Public No. (%)	Private No. (%)	Charity No. (%)	Public No. (%)	Private No. (%)	Charity No. (%)
	By state								
	Florida			New Jersey			Wisconsin		
0-20	37 (21)	148 (82)	136 (75)	10 (8)	102 (86)	109 (91)	15 (10)	127 (85)	142 (95)
21-40	8 (5)	10 (6)	12 (7)	1 (1)	7 (6)	7 (6)	1 (1)	6 (4)	5 (3)
41-60	23 (13)	7 (4)	12 (7)	6 (5)	2 (2)	2 (2)	5 (3)	3 (2)	3 (2)
61-80	18 (10)	3 (2)	6 (3)	17 (14)	1 (1)	1 (1)	31 (9)	2 (1)	0 (0)
81-100	91 (51)	13 (7)	15 (8)	86 (72)	7 (6)	1 (1)	115 (77)	11 (7)	0 (0)
Reporting facilities	177 (100)	181 (101)	181 (100)	120 (100)	119 (101)	120 (101)	149 (149)	149 (99)	150 (100)
	By stream of care								
	Welfare			Justice			Health		
0-20	23 (14)	150 (94)	123 (77)	0 (0)	79 (100)	78 (98)	17 (12)	95 (67)	134 (94)
21-40	5 (3)	2 (1)	9 (6)	0 (0)	0 (0)	2 (2)	3 (2)	18 (13)	6 (4)
41-60	12 (8)	0 (0)	13 (8)	0 (0)	0 (0)	0 (0)	20 (14)	11 (8)	2 (1)
61-80	10 (6)	2 (1)	4 (2)	3 (4)	0 (0)	0 (0)	27 (19)	3 (2)	0 (0)
81-100	109 (69)	6 (4)	11 (7)	75 (96)	0 (0)	0 (0)	73 (52)	14 (10)	0 (0)
Reporting facilities	159 (100)	160 (100)	160 (100)	78 (100)	79 (100)	80 (100)	140 (99)	141 (100)	142 (99)
	By auspice								
	Public			Private					
0-20	3 (2)	146 (94)	153 (98)	59 (20)	231 (79)	234 (79)			
21-40	0 (0)	5 (3)	1 (1)	10 (3)	18 (6)	23 (8)			
41-60	5 (3)	2 (1)	2 (1)	29 (10)	10 (3)	15 (5)			
61-80	7 (5)	1 (1)	0 (0)	41 (14)	5 (2)	7 (2)			
81-100	139 (90)	2 (1)	0 (0)	153 (52)	29 (10)	16 (5)			
Reporting facilities	154 (100)	156 (100)	156 (100)	292 (99)	293 (100)	295 (99)			

[a] Columns may not sum to 100 percent because of rounding.

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Examining the distribution of funds and funding sources by auspice of care at the highest level of public funding (over 80 percent), we see a much higher percentage of public than private facilities (90 percent vs. 52 percent, respectively). On the other hand, private funds supported over 80 percent of facility budgets among 10 percent of private facilities, compared with only 1 percent of public facilities.

These findings again demonstrate the general predominance of public funds in residential care, as well as the relatively greater role of private funds in supporting facilities that are privately, rather than publicly, operated.

SUMMARY

In general, the 478 residential care facilities across the three states were largely privately operated, had a median facility size ranging from 8 to 27 children, and were at least three-fourths filled to capacity. We found the median size of facilities and the number of children in them to be smallest in the welfare stream and largest in the justice stream. Also, for private facilities, the median facility size of 14 beds and the median daily census of 10 were approximately half of those in public facilities.

Looking at the flow of residents through the residential care system, we found the largest sources of referrals to residential care in all states to be social service agencies and the justice system, rather than families or medical sources. Wisconsin's 51 percent rate of referral by social service agencies was higher than for the other states, while its 24 percent rate of referral by the justice system was lower. Across the streams of care, social service agencies were the primary sources of referral to welfare and health facilities, but not to justice facilities. The finding that 96 percent of justice facilities received their residents through justice system referrals is not surprising: to enter the justice stream of care, juveniles go through courts, police, and other junctures in the justice system.

With respect to auspice of care, social service agencies and families were over twice as likely to make referrals to private facilities as to public ones.

Average length of stay in residential care facilities ranged from 6 months in New Jersey to 8 in Florida. Much more pronounced differences appeared in the duration of care in the different streams of care. Length of stay in justice facilities averaged 4 months, compared with over 7 months in welfare facilities and almost 1 year in health facilities. Residents in public facilities stayed 4 months, on the average, compared with 9 months in private facilities.

In studying where residents go when released from a given facility, we found that the majority, 62 to 78 percent, were released to their families. Residents leaving the justice stream and from Florida facilities demonstrated the highest rate of release to family. We found very little difference between public and private facilities in the proportions of children they released to families or institutions.

The final area examined in this chapter concerned sources of funding for residential care facilities and costs associated with care. Across all states, streams, and auspices, the majority of facilities received over 80 percent of their funds from public sources. The justice stream particularly stood out in its near-total support by public funds. Additionally, higher levels of charitable funding were found more frequently in Florida than in New Jersey and Wisconsin, and higher levels of private funding more frequently in the health stream than in welfare or justice.

The median daily cost per child ranged from $40 to over $60. Cost of care was lowest in Florida and in the welfare stream, approximating $40 per day. By contrast, cost of care was highest in New Jersey and in the health stream, approximating $65 per day. Public and private facilities differed little in the median daily cost of residential care.

CHAPTER 3

CHARACTERISTICS OF CHILDREN IN RESIDENTIAL CARE

In preparing to characterize the children in residential care in our three study states, we examined a study of broader scope done in 1981 by the University of Chicago on 131,419 children in residential care facilities nationally. They found that children in residential care facilities and their families generally face many serious problems, such as delinquency, emotional disturbance, and substance abuse. Furthermore, many of the children suffer these problems in tandem; that is, a child's problems are likely to be multiple, not discrete. These findings are illustrated by the distribution of data from the study, presented in table 6 on the next page.

As the table shows, family problems constituted the single largest category. Other problems shared by at least half of the population were peer problems, delinquency, and status offenses. Almost half of the children (48 percent) were categorized as depressed, and more than a third had been abused (40 percent) or had learning problems (37 percent). Approximately one out of every three children (35 percent) suffered from drug and alcohol problems, and 14 percent were considered suicidal.

Although we did not collect information concerning individual problems of children in residence, the fact that many problems and conditions occur in tandem was important in our decision to look at children in all three streams of care. In the following discussion, we present our findings on the age, sex, race, and family income level of children in residential care in the three study states, Florida, New Jersey, and Wisconsin. Each variable is examined at the three-state level for all facilities and then by stream of care and auspice of facility within each state. The totals do not always match across all states, either because not all responding facilities were placed in one of the three streams of care (as mentioned earlier) or because in providing information on racial composition, some mixed facilities (child and adult) included residents over 18. With respect to the data on family income levels, many facilities (262 or 55 percent of the total) either provided information that could not be used or none at all.

We preface our discussion of each variable with some brief information, drawn from U.S. Census data,[1] on the percent of each state's population comprised of children, the percentages of males versus females, and so on, to give the reader a framework

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[1] U.S. Bureau of the Census. 1980 Census of Population, Volume 1, Characteristics of the Population, Chapter B, Table 19, and Chapter C, Tables 71 and 81 (Washington, D.C.: 1982-83).

Table 6

Problems Manifest in 131,419 Children in Residential Care Facilities Nationally

	Children and youth with specified problems, conditions, or patterns by type of facility, 1981 (estimated numbers)[b]			
Problem, condition, or pattern[a]	Total	Welfare	Justice	Health
Family problems	95,985	22,741	43,746	29,498
Peer problems	77,558	14,237	35,692	27,629
Delinquent	66,565	4,142	53,997	8,426
Status offense	66,028	10,871	36,084	19,073
Depressed	62,856	12,335	28,822	21,699
Property crime	55,108	5,971	36,897	12,240
Abused	52,233	13,086	22,722	16,425
Learning problems	49,028	8,286	24,078	16,664
Drugs and alcohol	45,733	4,431	30,470	10,832
Violent	35,620	3,880	21,431	10,309
Sexual problems	22,179	3,673	10,662	7,844
Thought disorders	21,458	2,521	9,443	9,494
Suicidal	17,745	1,950	8,934	6,861
Mentally retarded	10,913	1,670	5,724	3,519
Physically ill	10,611	1,803	5,870	2,938
Physical handicap	9,068	1,495	5,038	2,535

[a] Listed in decreasing order of incidence across all three types of facility.

[b] Columns are not totaled, because an individual may have more than one problem, condition, or pattern of behavior, causing columns to sum to more than the total number of children studied.

SOURCE: University of Chicago, School of Social Service Administration. The National Survey of Residential Group Care Facilities for Children and Youth: Some Preliminary Findings, Table 6 (Chicago: April 1983).

for our findings. It should be noted that a child who is in residential care in a given state is not necessarily a resident of that state since children may come from other states. For instance, a facility in one state might make available special care or services that a child's home state could not provide. As we did not collect data on state origins of children, we cannot determine the extent to which out-of-state children represent all children in residence in any of the three states.

Our investigation of the 478 facilities across the three states produced the following demographic profile of the 10,549 children we studied:

- Geographic--More than half (54 percent) were in Florida;
- Age--Nearly half (48 percent) were between 12 and 15 years of age;
- Sex--More than three-quarters (76 percent) were males;
- Race--Almost two out of three (65 percent) were white;
- Stream of care--The largest group (36 percent) was found in the health care stream;
- Auspice--More children (58 percent) were in private facilities than in public (42 percent); and
- Family income--Most (66 percent) came from families who earned less than $15,000 annually.

In this chapter, we interpret the results one variable at a time, examining age, sex, race, and family income by our three dimensions of state, stream of care, and auspice of facility.

AGE: 12-TO-15-YEAR-OLDS USUALLY LARGEST CATEGORY

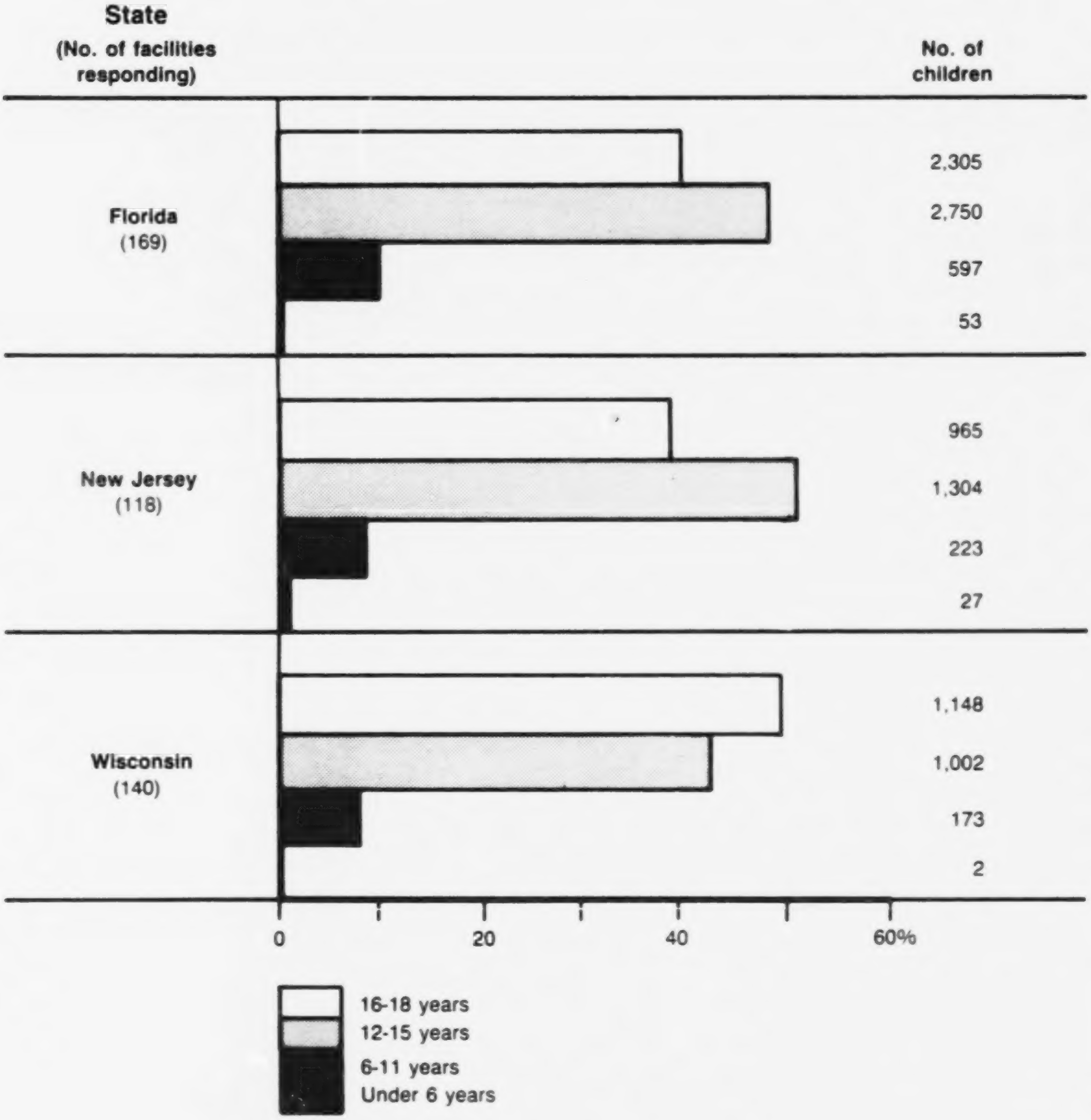
According to the U.S. Census, children 18 years of age and younger accounted for 26 to 31 percent of the general population in our three states in 1980. Florida had the lowest proportion (26 percent), followed by New Jersey (29 percent) and Wisconsin (31 percent). Our data on the age of children in residence by state is presented in figure 8, by stream of care in figure 9, and by facility auspice in figure 10, all on the following pages.

In Florida, 48 percent of the children in care were between the ages of 12 and 15 (see figure 8). Children aged 16 to 18 were the second largest group (40 percent). Those 11 years of age and under accounted for 11 percent of all placements.

Similar to Florida, the age category in New Jersey with the largest number of children in care was 12-to-15 years, representing over half (52 percent) of all children placed in the state.

Figure 8

Age of Children in Residential Care by State



Children aged 16 to 18 represented 38 percent of placements and children less than 12 years old, 10 percent.

Wisconsin differed in a number of ways from the other two states. Whereas nearly half of the children in residential care in Florida and New Jersey were in the 12-to-15-year-old category and approximately 40 percent in the 16-to-18-year-old category,

Figure 9

Age of Children in Residential Care by State and Stream of Care

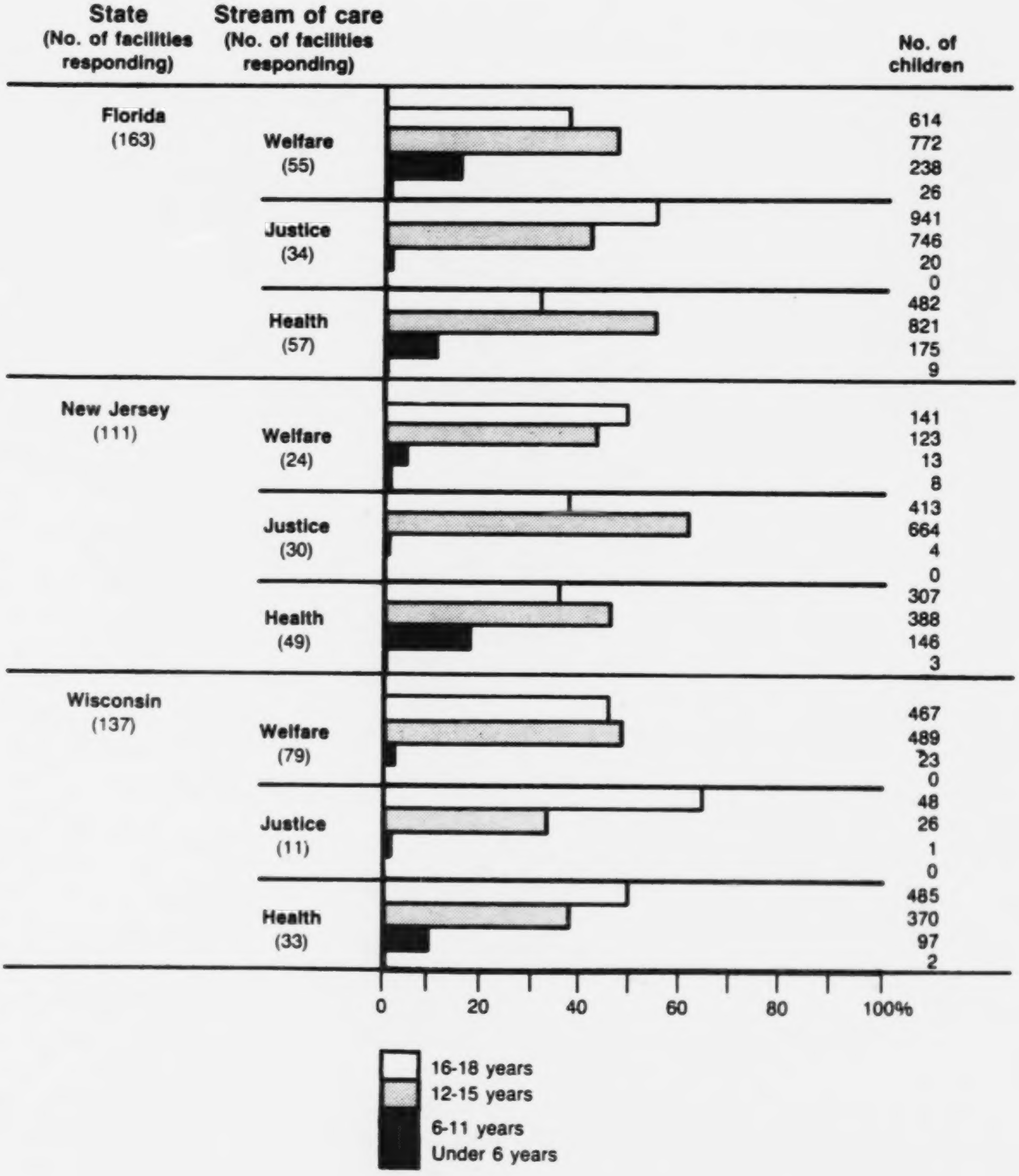
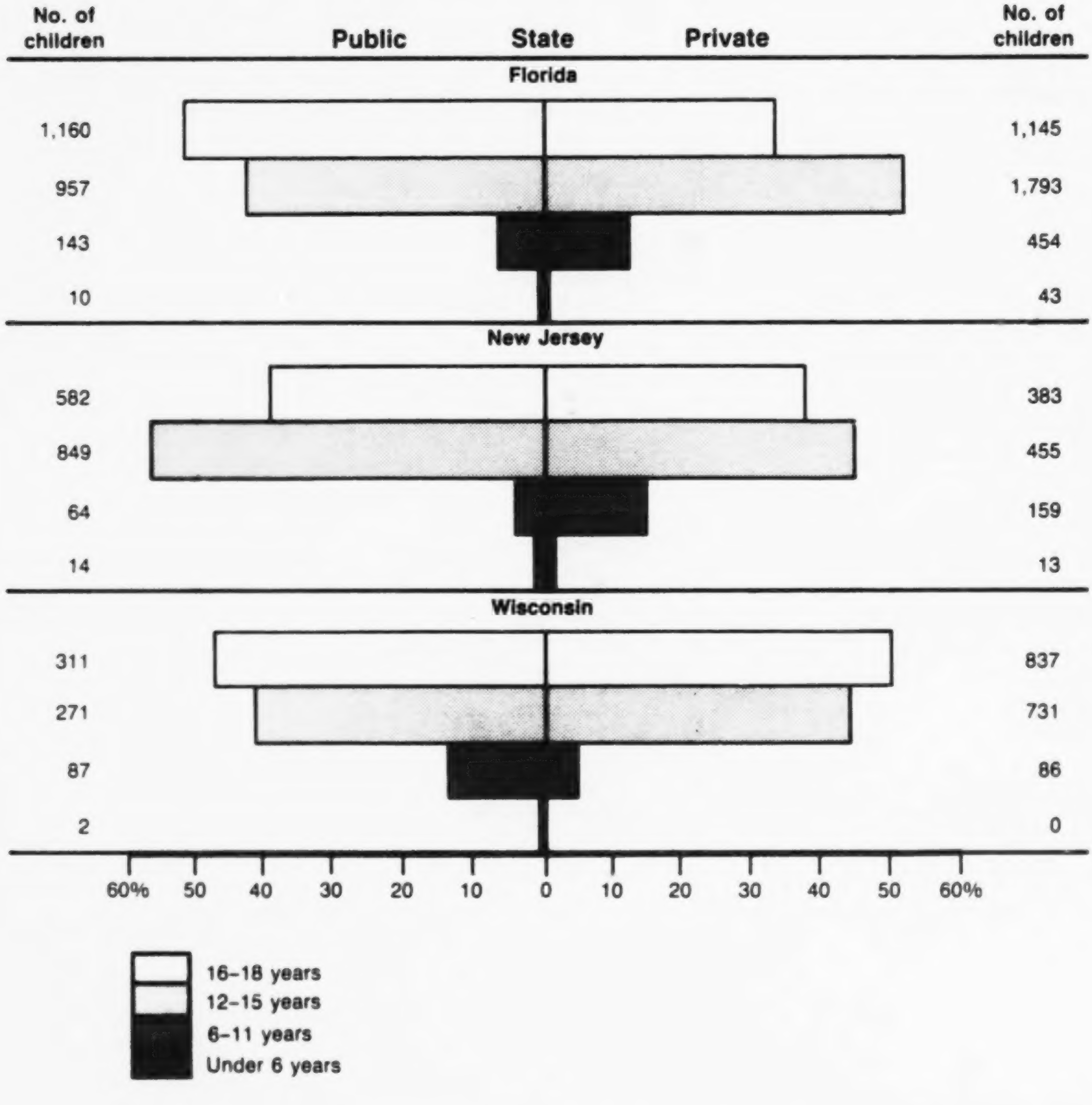


Figure 10

Age of Children in Residential Care
by State and Facility Auspice



Wisconsin inverted this relationship--49 percent between the ages of 16 and 18 and 43 percent between the ages of 12 and 15. Children younger than 12 accounted for 8 percent of those placed in Wisconsin.

When examining age distributions by stream of care for each state (figure 9), we note that in the welfare stream, Florida and

Wisconsin had the largest percentages of children in the 12-to-15 age category. This same category represented the largest percentage of children in health-oriented facilities in Florida and New Jersey. In justice facilities, New Jersey was the only state where 12-to-15-year-olds outnumbered all other age groups (61 percent, compared with 44 percent in Florida and 35 percent in Wisconsin).

With respect to facility auspice, figure 10 shows that New Jersey's facilities, both public and private, had the largest grouping of children in the 12-to-15-year-old category. In Wisconsin, the group aged 16 to 18 was predominant in both types of facilities. Florida's public facilities, however, had a relatively higher percentage of children aged 16 to 18 than did private facilities.

SEX: MALES PREDOMINATE IN RESIDENTIAL CARE

In the general population in each of our three states in 1980, the ratio of males to females 18 and under was identical: 51 to 49. As might be expected, however, males were in the majority in residential care facilities, whether viewed generally by state (figure 11 on the following page), or by stream of care or auspice (figure 12 on page 38). Overall, three-fourths (76 percent) of all placements were for males. New Jersey had the greatest proportion of males (80 percent), followed by Florida (77 percent) and Wisconsin (69 percent).

Of all male children in care, Florida and New Jersey placed a greater percentage into the justice stream than into either of the other two streams (42 and 55 percent respectively). Wisconsin placed half (51 percent) in the welfare stream. Derived from figure 12, by dividing number of males in one stream by total number of males for each state.)

Only 4 percent of Wisconsin males placed, however, went to justice-related facilities. We arrived at this by comparing the total number of males in the justice stream, 62, shown in figure 12, with the total of males in all three streams, 1,400. Again drawing on the numbers in figure 12, we observed New Jersey and Wisconsin to show the largest proportion of females in health facilities, 65 and 53 percent respectively. (These percentages resulted from a comparison of the number of females in the health streams with the totals in all three streams, 249 versus 385, and 325 versus 608, respectively.) In Florida, welfare facilities had the largest proportion of females, 51 percent (there were 572 in the welfare stream compared with 1,118 in all three streams).

Within each stream, males comprised the majority of children (figure 12). This was especially true in the justice stream (83 percent male in Wisconsin, 93 percent in New Jersey, and 91 percent in Florida).

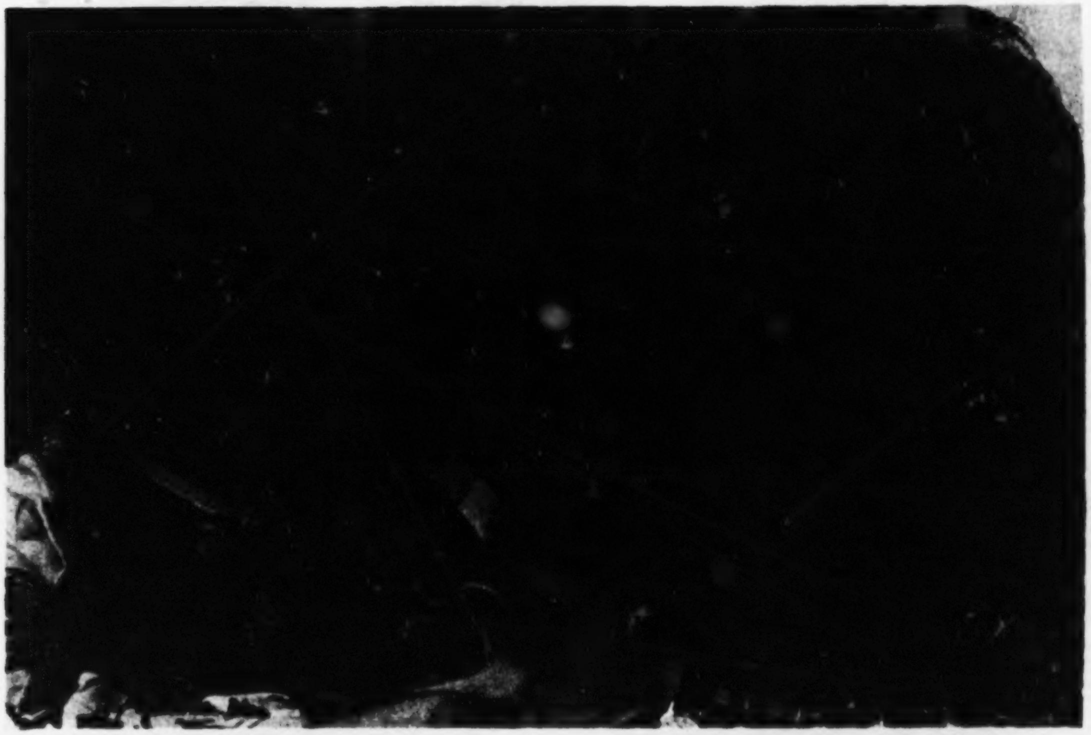


Photo courtesy of New Jersey Department of Human Services

In all three study states, males represented the overwhelming majority of children in residential care--over three-quarters of all placements. Here, a young man is assisted at the North Jersey Developmental Center in Totowa, New Jersey.

Males, in a ratio similar to their proportions in streams of care, outnumbered females in both public and private facilities (figure 12). The smallest difference in male/female percentages between the two types of facilities was found in Wisconsin and the largest in New Jersey.

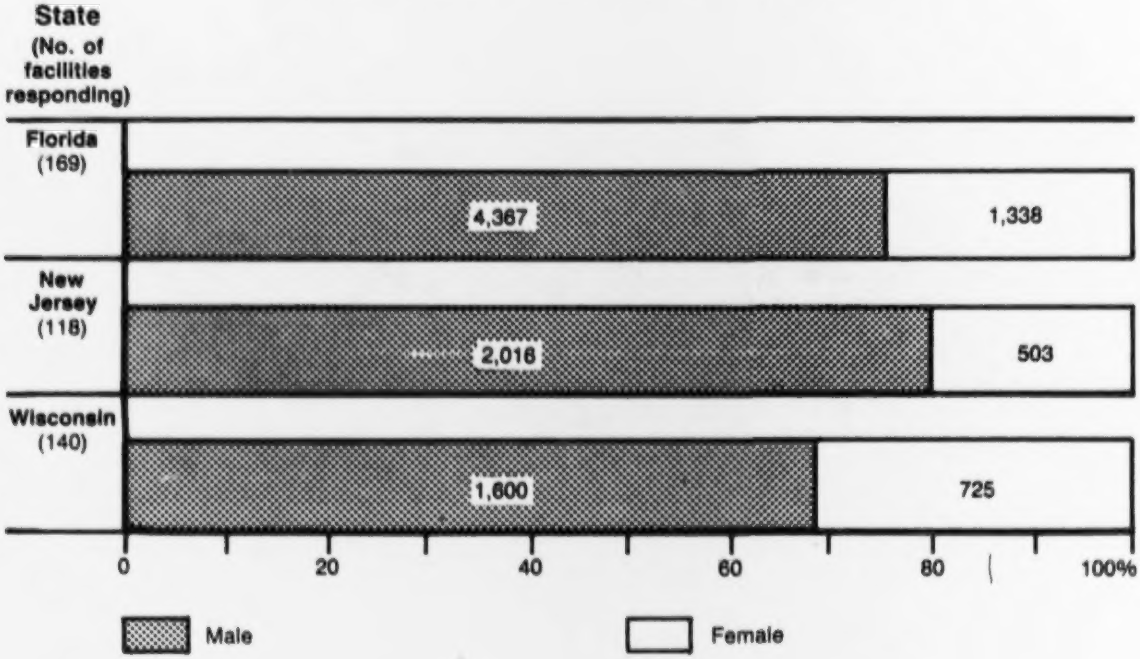
RACE: NONWHITE CHILDREN WERE PLACED AT HIGHER RATES, RELATIVE TO PROPORTION OF STATE POPULATIONS, THAN WHITE CHILDREN

About one-fourth of the general child populations of Florida and New Jersey in 1980 was nonwhite (24 percent in Florida and 23 percent in New Jersey), according to census data, while in Wisconsin, the figure was only 8 percent.

With respect to residential care, however, we found nonwhite children were placed at higher rates, relative to their percentage in the general population, than were white children across all three study states. Approximately one-third (35 percent) of all placements across the three states were for nonwhites. Of the

Figure 11

Sex of Children in Residential Care by State[a]



[a]Numbers within bars represent numbers of children; length of bars is based on percentages of totals.

three states, New Jersey had the highest proportion of nonwhite children in residential care (51 percent), as shown in figure 13 on the following page. The percentages of children in care who were nonwhite were 35 and 21 for Florida and Wisconsin, respectively.

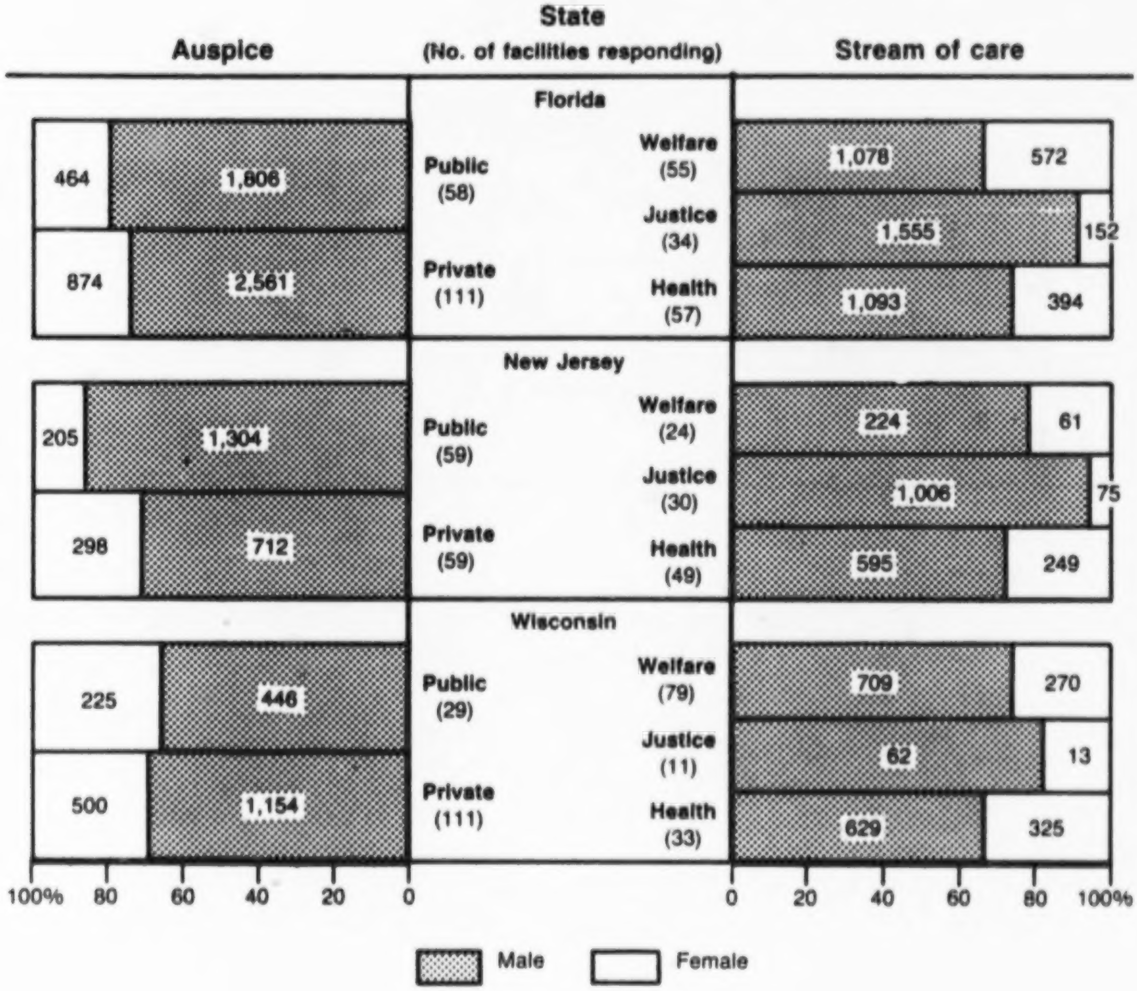
Concerning stream of care (figure 14 on page 40), the number of white children was greater than the number of nonwhite children in both the welfare and health streams for all three states. This balance was reversed for justice facilities, except for Wisconsin, which had more white than nonwhite children.

The proportions of white and nonwhite children in public and private residential care facilities for each state appear in figure 15 on page 41. Although the percentages of children in Florida placed in public and private facilities were relatively close (47 percent versus 53 percent), 62 percent of the nonwhite children were in publicly operated facilities. White children were more often found in private facilities (61 percent).

In New Jersey, more than half the children were in pulic facilities (54 percent public, 46 percent private). In terms of

Figure 12

Sex of Children in Residential Care by State, Stream of Care, and Auspice[a]

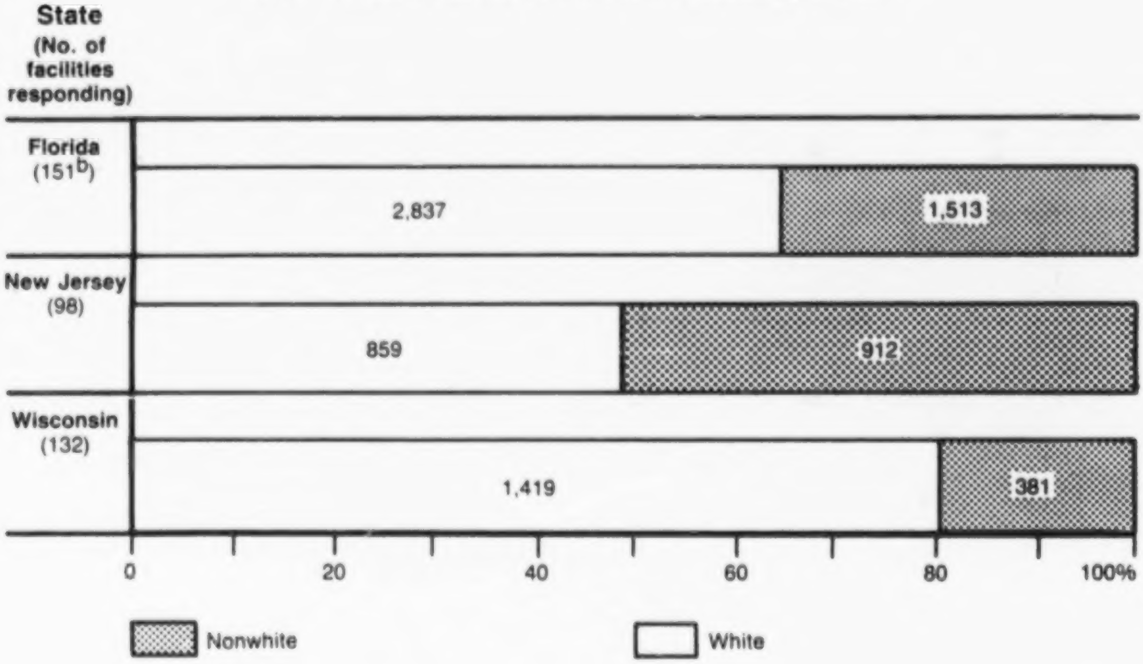


[a] Numbers within bars represent numbers of children; length of bars is based on their percentage distribution by sex.

race, however, there existed a significant difference. Over two-thirds (67 percent) of all nonwhite children were found in public facilities. White children were primarily placed in private facilities (60 percent). The composition of the population in public facilities shows that, for every one white child, there were nearly two nonwhite children (a 1.79 ratio); within private facilities, this ratio reverses, with nearly two white children (1.73) for every nonwhite child.

Figure 13

Race of Children in Residential Care by State[a]



[a] Numbers within bars represent numbers of children; length of bars is based on percentages of children in care in state.

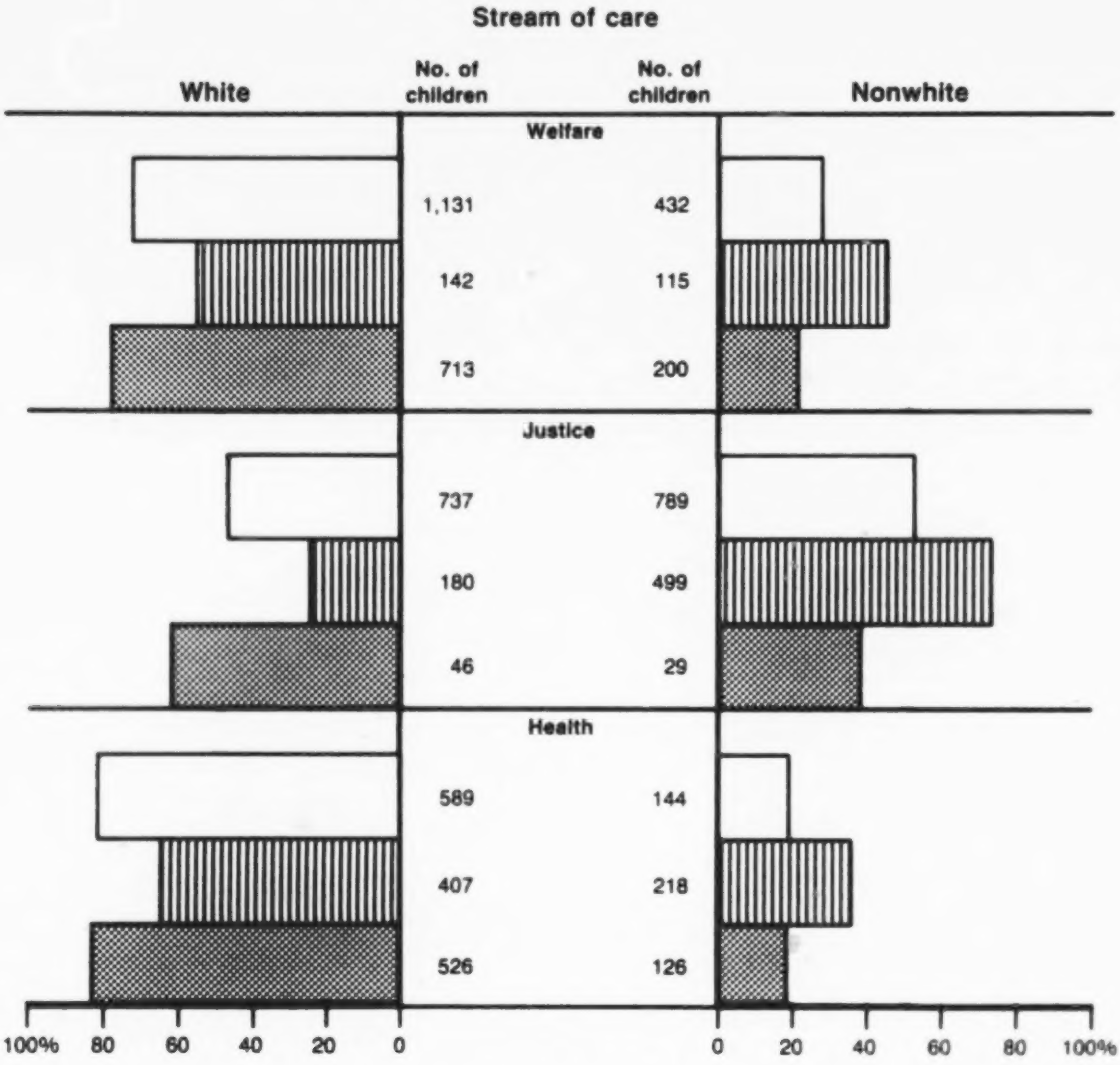
[b] 150 for nonwhites

In Wisconsin, there was very little difference in racial balance between public and private facilities. Slightly more than one-fourth of all children placed in Wisconsin were in public facilities (26 percent). Slightly more nonwhite (76 percent) than white children (74 percent) were placed in private facilities. Unlike the other states, Wisconsin's proportion of nonwhite to white children by facility auspices (public, 20 percent; private, 22 percent) almost equalled its overall proportions for all children placed (21 percent).

The relationship between race and placement in a public or private facility is examined in greater detail in chapter 5. It is important to recall at this point, however, that most of the financial support for private facilities derives from public funds, as we showed in discussing funding sources in chapter 2. An assumption, therefore, that differences in racial composition between public and private facilities are simply a function of ability to pay may not be supportable, since public monies contribute largely to both types of facility.

Figure 14

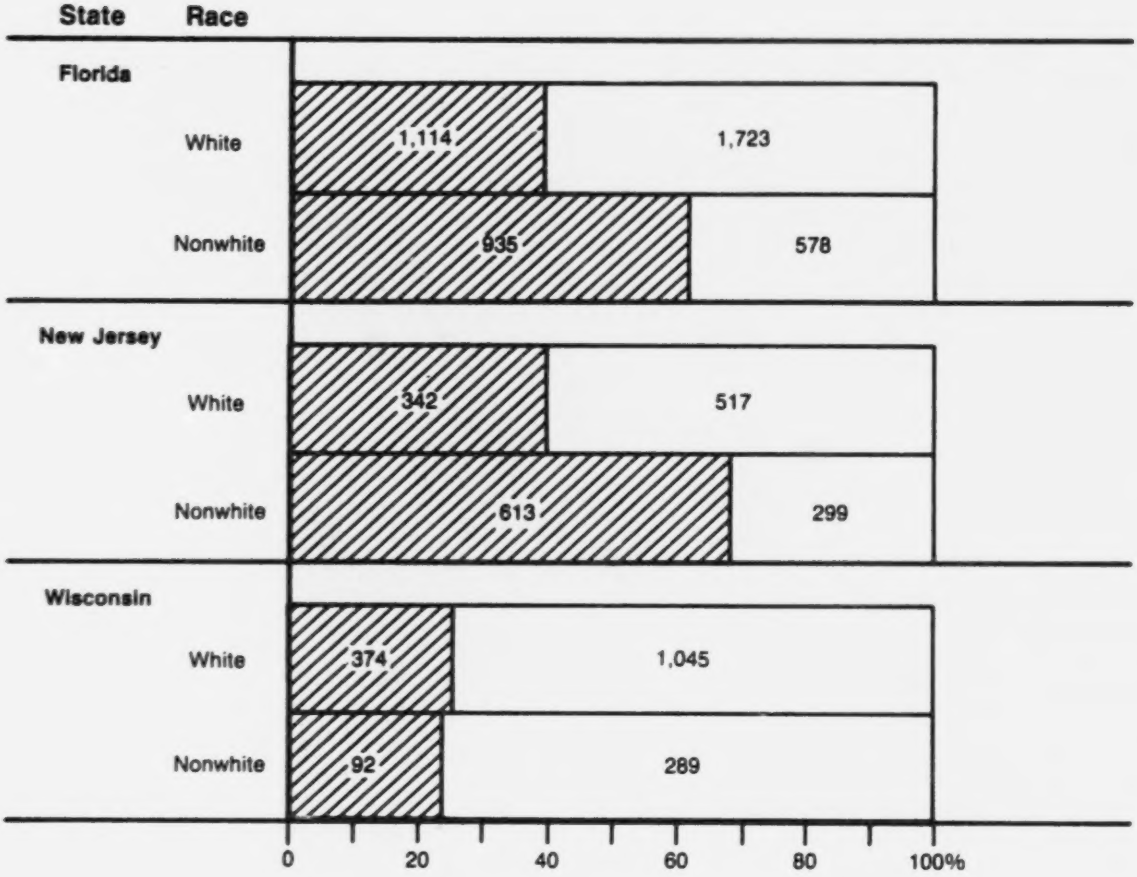
Racial Composition of Streams of Care by State



	No. of facilities responding		
	Welfare	Justice	Health
□ Florida	52	33	49
▥ New Jersey	23	26	39
▒ Wisconsin	77	11	29

Figure 15

Race of Children in Residential Care by State and Facility Auspice[a]



		No. of facilities responding		
		Florida	New Jersey	Wisconsin
☐	Private	95[b]	48	106
▨	Public	56	50	26

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[a] Numbers within columns represent numbers of children; length of bars is based on percentage of children in racial groupings.

[b] 94 for nonwhite

FAMILY INCOME: MANY FACILITIES PROVIDED NO DATA

Because many residential care facilities (262 out of 478 or 55 percent) in the three states did not provide information on the income levels of the families of their children, we can present data on less than half (41 percent) of the children in the study (see figures 16 and 17 on the following pages). The data therefore cannot be generalized to the state level.

In 1979, the census showed median family income for Florida families with children under 18 to be $18,270, the lowest of the three states we examined. Although we were unable in our study to determine the incomes for families by race, the census median was $19,974 for white families and $10,773 for black families.[2] Examining the distribution of residential placements across the states for four income categories (figure 16), we note that Florida's greatest number of placements had annual family incomes between $7,000 and $15,000 (40 percent), followed by those with incomes under $7,000 (29 percent). The third greatest number of children represented had family incomes between $15,000 and $25,000 per year (22 percent).

For New Jersey, the 1979 median income of families with children under 18 was $22,968, the highest of our three states. For white families, census figures showed $24,837, while for black families, it was $12,977. We found that 41 percent of families with children in placement had incomes under $7,000 (the single highest percentage for any income category in the state and across all three states), and 32 percent had incomes between $7,000 and $15,000. One in seven children (14 percent) had family incomes between $15,000 and $25,000, with 13 percent coming from families earning more than $25,000.

In 1979, Wisconsin families with children under 18 had an annual median income of $21,699, according to census data. Comparable figures for white and black families, were $22,077 and $11,701, respectively. Wisconsin had a smaller percentage of children in the under-$7,000 category (21 percent) than did the other two states. Similar to Florida, we found the category with the largest percentage of children to be $7,000 to $15,000 (38 percent). Children with family incomes between $15,000 and $25,000 accounted for 31 percent. The remainder (10 percent) were in the over-$25,000 category.

When we added stream of care as a variable (figure 17), we saw differences between streams that were consistent across the

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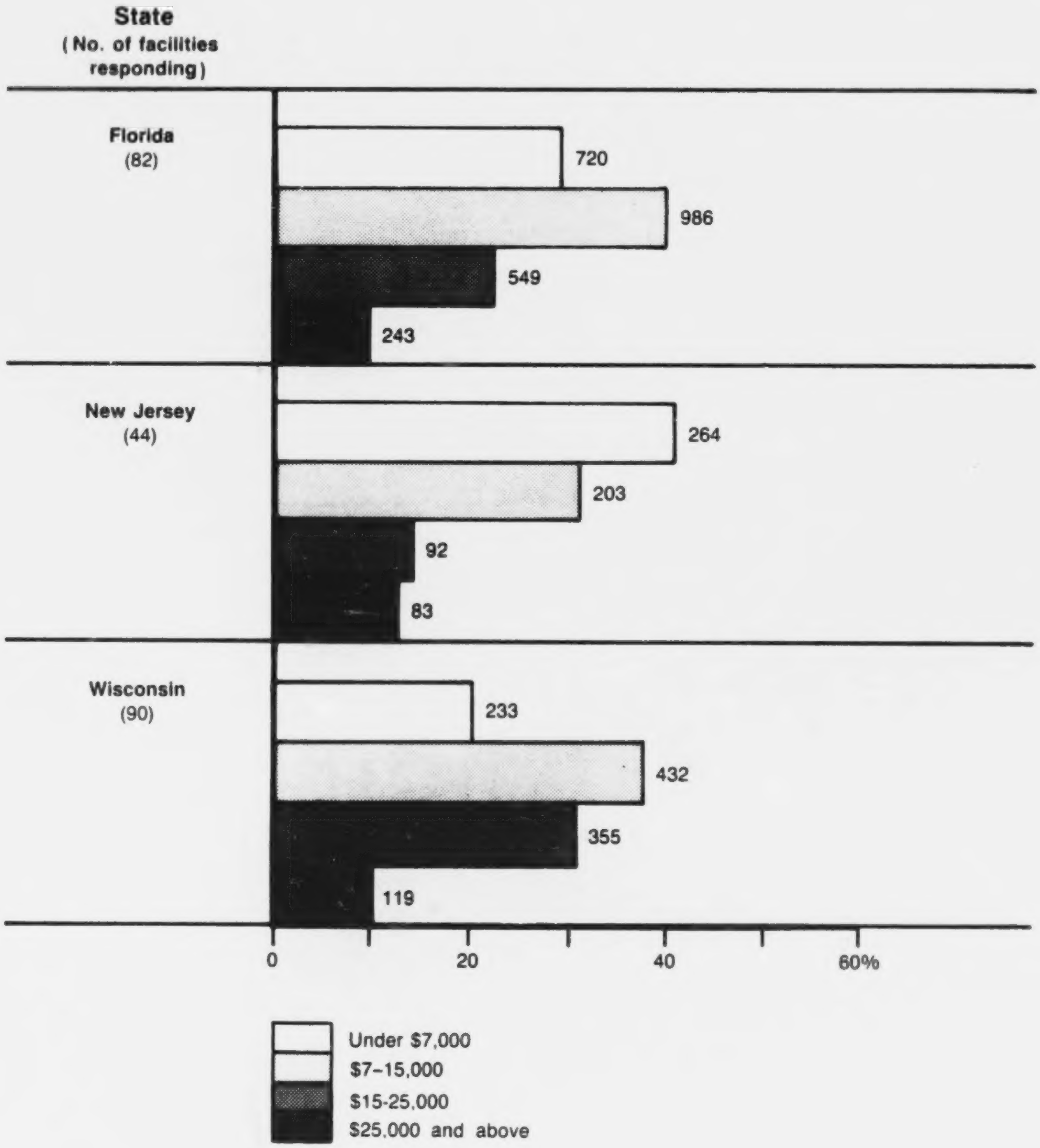
[2] Comparison here is made with black families because census data on nonwhite families (the category used in GAO's study) was not available.

Figure 16

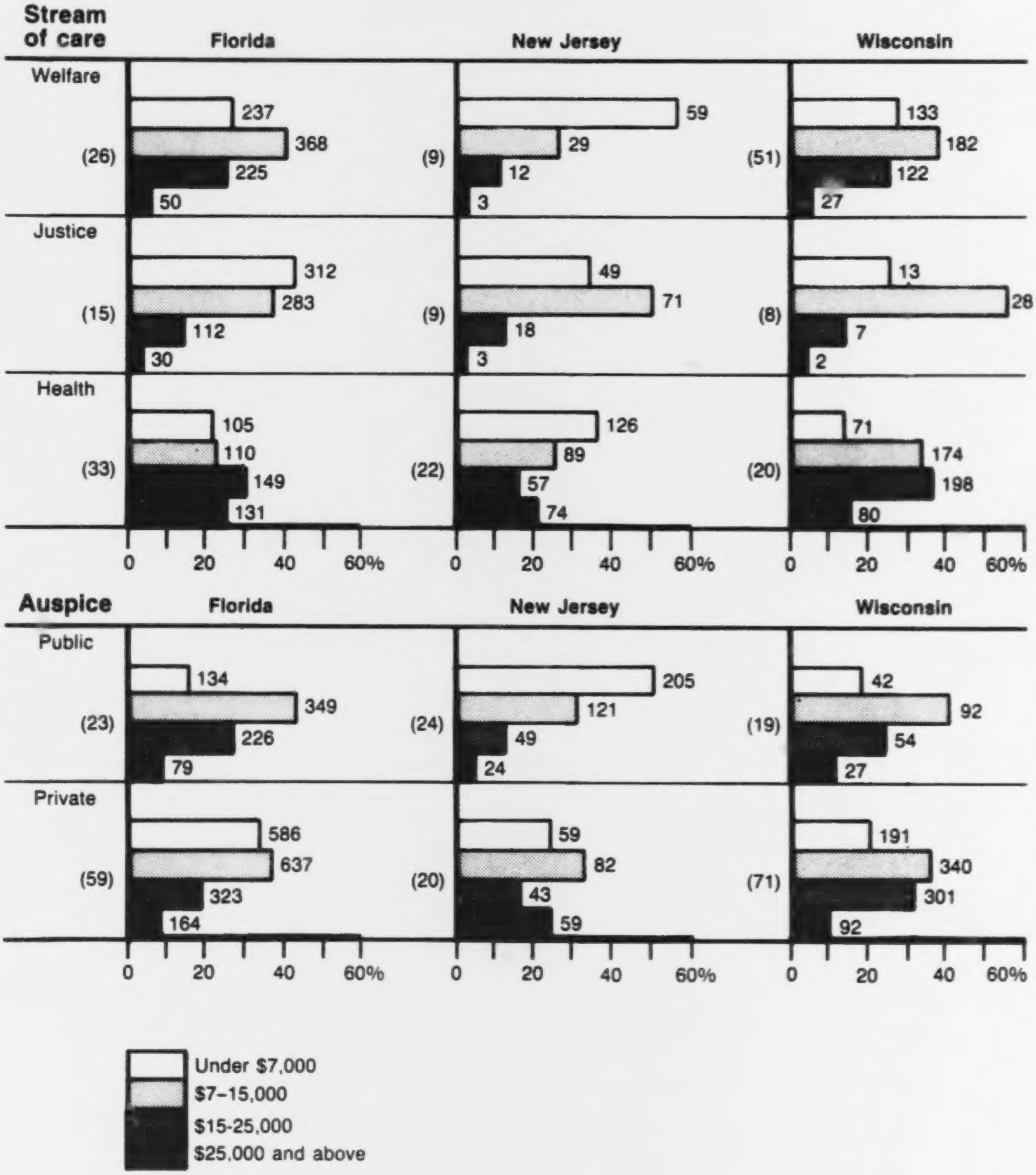
Family Income of Children in Residential Care by State[a]



[a] Numbers adjacent to bars represent numbers of children: length of bars is based on percent of each state s total

Figure 17

Family Income of Children in Residential Care by State, Stream of Care, and Facility Auspice[a]



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[a] Numbers adjacent to bars represent numbers of children; length of bars is based on percent of total in category; number in parentheses represents number of responding facilities.

three states. Most notably, the annual family income of children in the welfare and justice streams was mainly under $15,000 (68 percent in Wisconsin to 85 percent in New Jersey, reached by combining the percentages of the two lowest income categories). In New Jersey, over half (57 percent) of families with children in welfare facilities earned less than $7,000 per year.

The health stream, however, clearly serves a wealthier population. In Florida, over half of the children in health facilities (57 percent) came from families with incomes over $15,000; in Wisconsin, the figure was 53 percent. Compared with the other states, the health stream in New Jersey had a smaller percentage of higher-income families (38 percent earned over $15,000 per year), but still ranked high compared with the other two streams of care. (Again, these percentages represent the sum of the two highest income categories.)

Unlike stream of care, however, auspice of care as related to family income did not exhibit a pattern that held from state to state (figure 17). For example, when looking at the breakdown of family income for Florida's public and private facilities separately, we saw that public facilities served a smaller percentage of families earning less than $7,000 (17 percent) than did private facilities (34 percent). In New Jersey, we found the opposite; 51 percent of families with children in public facilities earned under $7,000 compared with 24 percent of private sector families. In Wisconsin, with roughly equal proportions of families in public and private facilities earning less than $7,000 (20 and 21 percent, respectively), neither the Florida nor the New Jersey findings hold.

SUMMARY

This chapter provides an overview of the demographic and socioeconomic characteristics of 10,549 children in 478 responding residential care facilities in three states and three streams of care, under two auspices. Over half of these children were in Florida facilities, over three-fourths were male, nearly two-thirds were white, and nearly half were between the ages of 12 and 15. More children were in health stream facilities than welfare or justice, and more children were in private facilities than public. Two-thirds of the children came from families with annual incomes of less than $15,000.

- Age. Our examination of the age groups served by residential facilities revealed some differences among states. Wisconsin, for example, had generally older children in care than did the other two states. Approximately half of the children in Wisconsin facilities were 16 to 18 years of age, whereas approximately half of the children in Florida and New Jersey facilities were 12-to-15 years of age. Looking at streams of care within states, we found that 12-to-15-year-olds comprised the largest percentage of children in the welfare stream in Florida and

Wisconsin, and the largest percentage of children in the health stream in Florida and New Jersey. Among justice facilities, only New Jersey served more 12-to-15-year-olds than other age groups.

- Sex. Males predominated in residential care in each of the three states, in each of the three streams, and in each auspice. In each dimension, over 60 percent of placements were male. Looking at the distribution of males across the streams of care, we found that males were most prevalent in justice facilities in Florida and New Jersey and in welfare facilities in Wisconsin. In every state, over four-fifths of children in the justice stream were male.

- Race. Nonwhites comprised approximately one-third of all placements across the three states. Florida was representative of the three-state racial distribution, with 35 percent of its placements nonwhite. New Jersey facilities had a larger composition of nonwhites (51 percent), and Wisconsin facilities a smaller component of nonwhite children (21 percent). Comparing streams of care, every state had a higher percentage of nonwhites in justice facilities than in welfare or health facilities. Also, every state had a lower percentage of nonwhites in health facilities than in welfare or justice facilities.

When the racial composition of facilities was examined in terms of auspice of care, Wisconsin stood out. Overall, public and private placements in Wisconsin were comparably distributed across racial groups (approximately 75 percent of each racial group having been placed in private facilities and 25 percent in public facilities). In Florida and New Jersey, on the other hand, public placements were considerably more frequent among nonwhites than among whites. In those two states, respectively, 62 and 67 percent of nonwhite children were in publicly operated facilities. White children, in contrast, were more often found in private facilities (61 percent in Florida, 60 percent in New Jersey).

- Income. With respect to family income, we found that overall, the majority of families with children in residential placement in each state earned under $15,000 per year. Interpretation of our results, however, must be tempered by the fact that only 216 facilities (45 percent) provided data on the family income of their residents. New Jersey, with 73 percent of its families earning less than $15,000 per year, served the poorest population of residents. Indeed, a full 41 percent of New Jersey families with children in residential care earned less than $7,000 per year. In Florida, 68 percent of families had incomes under $15,000 per year, and Wisconsin came in third with 58 percent of its residents' families earning less than $15,000.

Earnings under $15,000 per year were also common among the families of residents in the welfare and justice streams. This was most prevalent in the justice stream, where over four-fifths of families in each state earned under $15,000 per year. In contrast, incomes over $15,000 were relatively more common in the health stream. Over half of Florida's and Wisconsin's families were in this higher-income category.

We also analyzed family income in terms of auspice of care. Similar to many of the earlier findings, the majority of residents' families under each auspice in each state earned less than $15,000 per year. There was no consistent pattern across the states, however. In Wisconsin we found little difference between public versus private facilities in the income distribution of residents' families. In Florida, on the other hand, low-income earners were more prevalent among private facilities than among public facilities, while the reverse was true in New Jersey.

CHAPTER 4

THE PLACEMENT PROCESS

In this chapter, we examine residential placement practices in the three study states, Florida, New Jersey, and Wisconsin, beginning with the six basic steps in placement. These are followed by a discussion of similarities among the three states' placement philosophies. The third section analyzes differences among the states affecting who is involved in placement decisions. Throughout these three sections, the discussion is restricted to "governmental placements," those in which a government agency is involved. The final section of the chapter introduces the concept of nongovernmental placements, where no state or county agencies are involved.

In this chapter, we deal with child placement at a general level, presenting only the basic steps involved in a placement decision. This is because delineating all the steps for all types of children in each state would be an undertaking beyond the scope of this report.

For an illustration of what would be involved, figure 18 shows the case-processing procedure for delinquents in Florida, as prepared by the Florida Department of Health and Rehabilitative Services. While the boxes, diamonds, and ovals portray the case flow at a general level, they do not give the reader a precise idea of what transpires at each step and who the relevant actor is. Consider just the set of three ovals at the upper left-hand corner. The broad categories--Law Enforcement, HRS Agent, and Others--do not delineate exactly who these actors are, nor is it made clear under what circumstances they may or must bring a child to intake. Much the same can be said with respect to other steps in the process shown in the chart. Further, the chart pertains to only one type of placement process (for delinquents) in one of the three states (Florida). It was for these reasons that we took the general approach in describing child placement.

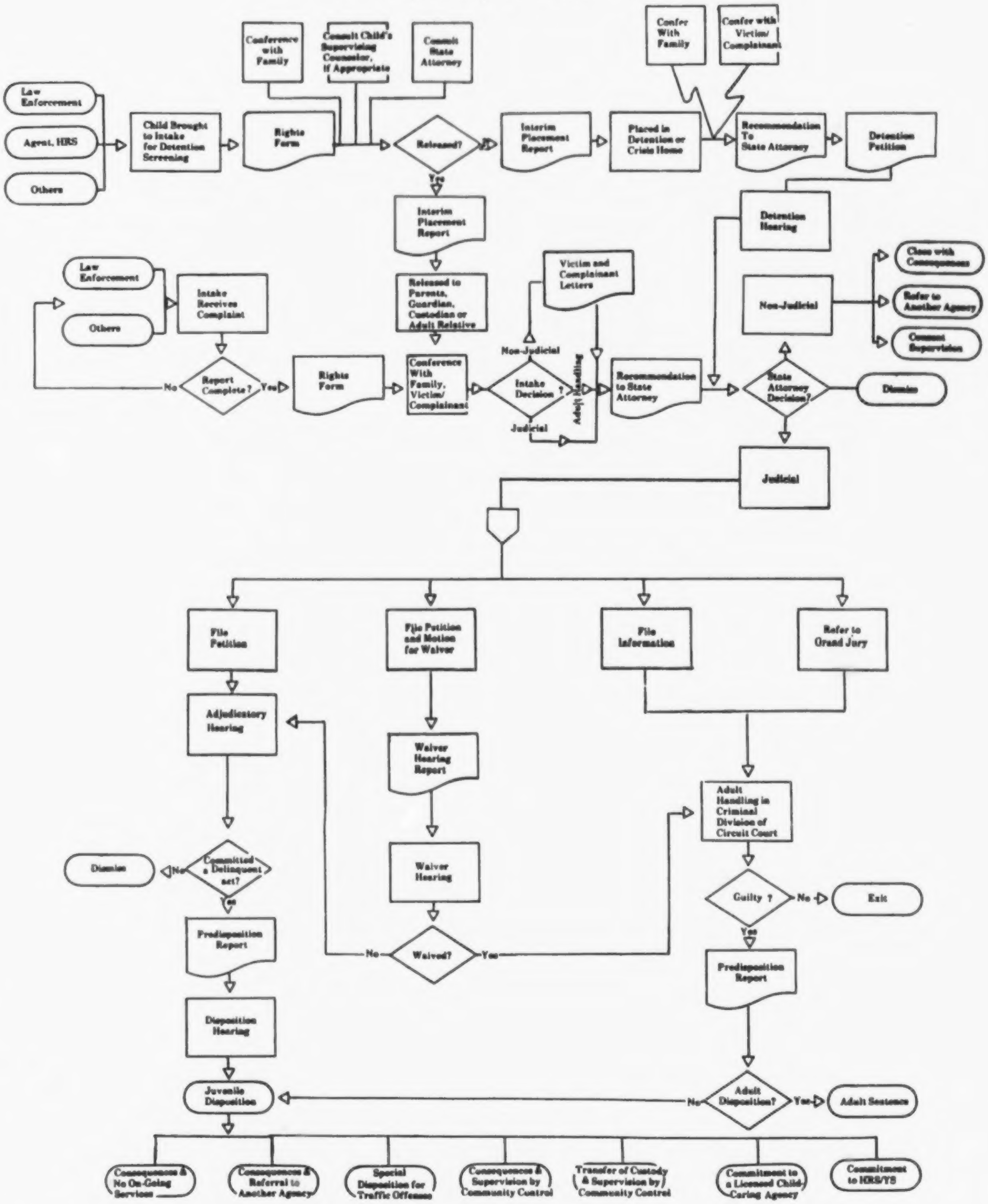
PLACEMENT: SIX BASIC STEPS

This section is directed primarily to readers who are unfamiliar with how children get placed in residential care environments. The successive steps, presented below in detail, consist of: identification of the problem, intake, diagnosis, recommendation for placement, placement decision, and implementation of that decision. In the following discussion, we identify the actors involved in each step and the kinds of decisions they are responsible for making.

1. Identifying the problem. All placement processes begin with the recognition that there exist problems that might call for removal of the child from his or her home environment. Various individuals, including parents, law enforcement agents, school officials, neighbors, physicians, and even the child, may be in a

Figure 18

Delinquency Flowchart[a]



Law Enforcement
Agent, HRS
Others
Child Brought to Intake for Detention Screening
Rights Form
Conference with Family
Consult Child's Supervising Counselor, If Appropriate
Consult State Attorney
Released?
Yes
Interim Placement Report
Placed in Detention or Crisis Home
Confer With Family
Confer with Victim/ Complainant
Recommendation To State Attorney
Detention Petition
Detention Hearing
Interim Placement Report
Released to Parents, Guardian, Custodian or Adult Relative
Law Enforcement
Others
Intake Receives Complaint
No
Report Complete ?
Yes
Rights Form
Conference With Family, Victim/ Complainant
Victim and Complainant Letters
Non-Judicial
Intake Decision ?
Adult Handling
Judicial
Recommendation to State Attorney
State Attorney Decision?
Dismiss
Non-Judicial
Close with Consequences
Refer to Another Agency
Consent Supervision
Judicial
File Petition
File Petition and Motion for Waiver
File Information
Refer to Grand Jury
Adjudicatory Hearing
Waiver Hearing Report
Waiver Hearing
No
Waived?
Yes
Adult Handling in Criminal Division of Circuit Court
Dismiss
No
Committed a Delinquent act?
Yes
Predisposition Report
Disposition Hearing
Guilty ?
No
Exit
Yes
Predisposition Report
Juvenile Disposition
No
Adult Disposition?
Yes
Adult Sentence
Consequences & No On-Going Services
Consequences & Referral to Another Agency
Special Disposition for Traffic Offenses
Consequences & Supervision by Community Control
Transfer of Custody & Supervision by Community Control
Commitment to a Licensed Child-Caring Agency
Commitment to HRS/YS

[a] Source: Florida Department of Health and Rehabilitative Services. "Dependency and Delinquency Intake: Single Intake for Delinquent and Dependent Children and Youth." HRS Manual 210-1, September 1, 1980 (updated May 1982).

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position to recognize such a problem. Once this happens, the child may be brought directly to a state or county agency for intake. For example, police may apprehend a juvenile for violation of a criminal statute and transport him or her directly to the court.

Alternatively, awareness of the problem may trigger a process of inquiry, discussion, and information gathering prior to initiating placement. A parent who suspects that a child is emotionally disturbed, for instance, may consult with friends, teachers, and psychiatrists before bringing the matter to the attention of a state or county agency.

As can be seen, the identification stage can be very short, in the case of delinquency, or extended over months and even years.

2. Intake. In the second step, there is official recognition of the potential need for residential care. This occurs when the identifying individual brings the problem to the attention of the relevant state or county agency (i.e., juvenile court or social services, welfare, or mental health department). Usually, there are intake workers or caseworkers whose responsibilities include collecting and documenting relevant information about the child, the family, and the specific incident that precipitated the decision to contact the agency.

Similar to the identification step, intake can be a singular or multi-tiered process. In New Jersey, for example, a caseworker for the Department of Youth and Family Services may be the only responsible agent for intake of a dependent child, whereas in Wisconsin, the social service intake is a preliminary step preceding intake by an employee of the juvenile court.

3. Diagnosis. Once a child is accepted by an intake worker, the problem must be diagnosed. The term "diagnosis" is most closely associated with medical problems and, where a health problem is assumed to exist, this step is usually performed by a medical professional. Included under health problems are cases of abuse, retardation, physical handicap, emotional disturbance, substance abuse, and mental illness.

For children in the justice or welfare streams of care, the nature and extent of the problem frequently are assessed by the intake worker, who decides whether there is sufficient evidence to assume that a child is delinquent or dependent or has been neglected. Once again, this step can be performed by a single individual or by a series of individuals.

4. Recommendation. Based on the diagnosis, a recommendation is made as to whether residential care is appropriate, and, if so, the type of care most suitable under the circumstances (e.g., group home, psychiatric hospital, shelter care, etc.). In some cases, intake workers and diagnosticians are required to make

recommendations for placement; in other situations, they have the right, rather than the obligation, to do so. The recommendations are forwarded to the individual or agency responsible for actually deciding whether a placement should be made.

5, 6. Placement decision and implementation of decision. The actual determination to remove a child from the home environment is the placement decision. In some situations, the individual who makes this decision has the authority to stipulate exactly where the placement is to be made and its other facets (e.g., length of stay, review procedures, treatment plan, related services, etc.). In cases where the placing agent does not specify any of these issues, the process moves to the final stage, implementing the decision, at which time a facility is selected and the nature of the stay decided upon.

While the foregoing description of the placement process applies generally, it implies a chronology that is often not adhered to. For example, diagnosis may precede intake, as when a psychiatrist refers a child to a social service agency after the diagnosis has been completed; recommendation for placement may come before diagnosis; and, in extreme cases (abuse for example), removal from the home may be the first step, taken to protect the child, followed by intake, diagnosis, and recommendation for further action.

Another discrepancy between our conceptual model and reality: a six-step process is portrayed, when in fact each step may consist of a lengthy series of sub-steps. A caseworker, for example, may make a recommendation to the supervisor who, in turn, requests the opinions of an agency psychologist, who modifies the recommendation and returns it to the caseworker, who checks with the parents, who employ an attorney, who makes a counter-recommendation, and so on.

Also, it may appear that each step is discrete, and a different individual is responsible at each step. In some cases, this is accurate. For example:

- A police officer arrests a juvenile for possesion of heroin (identification) and transports the child to the juvenile court;
- A court employee begins the documentation (intake) and refers the case to a unit that determines whether a drug dependency exists (diagnosis);
- The prosecutor's office and defense counsel meet and make a joint recommendation to the judge about placement in a substance-abuse program (recommendation);
- The judge decides that the program is appropriate (placement decision) and refers the case to the department in charge of the program; and

- Program staff then work out the details of the placement (implementation).

In other instances, however, the same individual, most often the social service department caseworker, may be involved in many steps. An example is the caseworker who

- as a result of interaction with a family suspects that the parents are abusive towards their child (identification);
- requests that the family come in to discuss the matter (intake);
- determines on the basis of that discussion that the child is in danger (diagnosis); and
- arranges for immediate placement in an emergency shelter to protect the child (recommendation, decision, implementation).

Despite this diversity of activities, actions, and steps in placement, our review of placement policies in the three states uncovered considerable consistency in stated philosophies on the how, when, and why of placement.

CONSISTENCIES IN PLACEMENT PHILOSOPHIES

The legislation and operating manuals we reviewed indicate that the three states share a common policy, that removal of a child from the home is a drastic step to be recommended only when all other options have been exhausted. Another common policy was that, if out-of-home placement is deemed necessary for the benefit of the child, the placement should be made in the least restrictive form possible.

Another similarity across the three states was the legislative distinction made between delinquents, i.e., children who committed crimes, and status offenders. By status offenses, we mean activities which, if engaged in by an adult, would not constitute law-violating behavior, such as running away from home, truancy, consumption of alcohol, and sexual promiscuity.

We were not surprised to find our three states similar in their perspectives on removal from the home, minimum level of restrictiveness, and distinguishing between delinquents and status offenders, as federal law addresses these three issues. But we found other similarities in the states' approaches to placement decisions as well:

- Multi-disciplinary review committees, responsible for recommending whether placements should be made and/or actually deciding on placement. Their existence indicates a desire for a control mechanism to insure that children are not placed in residential care too cavalierly.

- Recognition that expertise from many areas is often necessary for appropriate diagnoses and placement recommendations. Policy manuals encourage social service caseworkers, court intake workers, and other agents officially in the placement stream to avail themselves of the services of physicians, psychologists, and other experts who might help in making decisions that would most benefit the children.

- Permanency planning, a doctrine whose stated objective is to attain permanency in the child's life as quickly as possible. Thus, when a placement is made, consideration is given to the negative consequences of moving the child in and out of various environments haphazardly. The placement period is made long enough for the program to deal adequately with the problem that precipitated it. If multiple placements are necessary, e.g., a drug-abuse program followed by a community-based group-home, these are planned at the outset. Throughout the process, the objective is to return the child to the family as quickly as possible.

- Voluntary placement, the option for an informal agreement between the child, the parents, and the state or county agent. We found this existed in every process, for each stream of care, and for each state. Informal, voluntary placement is apparently preferred because it may not be as stigmatizing as official placement, and it involves the parents as active participants in the decision to make the placement.

SOME DIFFERENCES IN STATE PRACTICES

We found many minor differences among placement practices in the three states, as well as three variations that we judged important, because they resulted in either different types of individuals being involved in placement decisions or different levels of involvement. These variations involve the role of the court, state and county responsibilities, and the role of county education departments:

1. Role of the court. All three states had juvenile or family courts with the authority to place children in residential care. In Wisconsin, however, our interviews with state and county officials indicated that the courts were more active in the placement process than were the courts in either of the other two states. We found this primacy of the court unusual, because it created a situation in which a state official (the judge) made decisions impacting directly on county resources (i.e., residential placements to be paid for with county funds).

2. State and county responsibilities. Each of Wisconsin's 72 counties had its own social service department, the organization most responsible for children in residential care. In Florida, a very different structure existed: the state social service agency provided services at the local level through 11 district offices. New Jersey seemed to mix the two models by having state social service offices located in each of the counties. Control of funding for residential services also varied. Both Florida and New Jersey retained that control at the state level; in Wisconsin, the counties had greater authority in the allocation of funds. Are these differences in level of responsibility significant in their implications for placement practices? They would be if it could be determined that state and county employees differ in their placement decisions.

3. Role of county education departments. Participation by county education departments in the review of placement decisions differed considerably among our states. Implementing a federal requirement[1] that education and related services be made available to all physically or emotionally handicapped children, New Jersey formally included school district representatives on their review panels. Such a panel, the Child Study Team (CST), reviews all potential placements made by the State Division of Youth and Family Services (DYFS), and its evaluation is critical. The CST must include a certified school social worker from the child's school district, an educational psychologist appointed by the school district, a learning disabilities' specialist, and possibly a psychiatrist. It is reasoned that, since the school district must pay for the educational component of residential care, it should have some role in the placement decision.

In Florida, the composition of the equivalent panel, called the case review committee (CRC), was not as heavily oriented toward educational considerations. While it had fairly similar functions to New Jersey's body and required a school system representative to be a member, the CRC's mandatory membership also included a licensed clinical psychologist or psychiatrist and representatives of the Children, Youth, and Families District Program office; the district Alcohol, Drug Abuse, and Mental Health Program office; and each of the district's Mental Health District Boards.

As mentioned previously, Wisconsin had a county-based service delivery system in which there could be procedural variations across the counties. Officials from three Wisconsin counties indicated in interviews that a panel reviews all placement decisions at some point in the process. These panels, however, do not usually include representatives from the education system, in contrast to New Jersey and Florida.

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[1] P. L. 94-142, Education for All Handicapped Children Act of 1975 (20 U.S.C. 1400 *et seq*. 1976).

Photo courtesy of New Jersey Department of Human Services

In New Jersey, state social service offices located in each county nandle residential care for children. The North Jersey Developmental Center in Totowa is where this youngster lives and receives services.

We also found some seemingly trivial variations in procedures or administrative detail among the three states, such as differences in names of departments and numbers of copies made of case files. Since we had no criteria for significance, it was difficult to judge their importance. One example should illustrate the point:

In Wisconsin, only children placed in one of two institutions, Lincoln Hills or Ethan Allan (total population approximately 500), come under the purview of the Division of Corrections. Other children placed in residential care because of delinquency convictions are the responsibility of county social service departments. If a child leaves Lincoln Hills or Ethan Allan and is placed in a community-based group home, he or she remains the responsibility of the Division of Corrections.

In New Jersey, however, there are more children in institutions under the auspices of corrections. But, should these children be moved to a group home, their cases are transferred to the Division of Youth and Family Services.

Is the difference significant? The answer depends on a set of issues that go beyond the scope of this study, e.g.: do differences exist between corrections' and social services' contractual relationships with group homes? Do the respective agencies employ differential standards to determine which children should be placed or returned to their families after leaving the correctional institutions? and so on.

ROLE OF THE PARENT IN PLACEMENT

We noted earlier the six basic steps that occur in any placement. In listing the actors involved, the parents of the child were mentioned only with respect to the identification of the problem. Obviously, they may also be actors in other steps, most notably diagnosis (e.g., "My child is incorrigible.") and recommendation (e.g., "I think a home for emotionally disturbed children would be appropriate."). What is perhaps less obvious is that the parents may be the only parties involved in all steps of the process in situations ranging from an informal agreement with relatives who will care for the child to parents placing their children in private psychiatric hospitals for months at a time.

Throughout the remainder of this report, we refer to placements effected by parents without contact or consultation with state or county officials as "nongovernmental." Also included in this category are placements arranged by private physicians and private social service agencies of which the state or county has no awareness. We refer to placements that involve public employees in a consultive or decision-making capacity as "governmental."

In the next chapter, we examine the relationship between several factors that influence placement and whether a child is placed in care through governmental or nongovernmental processes.

CHAPTER 5

FACTORS ASSOCIATED WITH TYPE OF PLACEMENT

This chapter focuses on the relationship between various characteristics of children and their families and the type of placement effected--whether the children are placed in residential care through governmental or nongovernmental processes. Using data from our questionnaire (appendix III), we examine the relative prevalence of governmental and nongovernmental placements in our three study states (Florida, New Jersey, and Wisconsin) generally, and the sources that refer children to residential care specifically. In addition, we use case-record data to explore associations between type of placement (governmental/nongovernmental) and 1) characteristics of residents and their families and 2) the availability and use of private health insurance. Finally, for a subgroup of the sample, we present differences in the racial composition of public and private facilities.

Was it necessary to examine residential placements made without governmental involvement? We believe it was, for several reasons. First, it is important to understand how pervasive nongovernmental placements may be. By examining only those children placed in residential care through their own agencies, states and counties might well underestimate the magnitude of the child population in need of residential services. Moreover, to determine the significance of findings on governmental and nongovernmental placements and how representative they were, it was necessary to know the size of the universe.

Second, it was important to examine whether the opportunity to place a child through a nongovernmental process is uniform for all families. Third, as the federal government has played an active role in promoting permanency planning, least restrictive form of intervention, deinstitutionalization, and due process for children in residential care, concern as to whether or not nongovernmental placements conform to the precepts underlying these policies is legitimate.

We should emphasize that the results presented in this chapter are drawn from two distinct sources:

1. A survey of 10,549 children in 478 residential care facilities in our three study states, from which came our findings on the extent of nongovernmental placements and the association between race and type of placement, and
2. Individual-level data collected from 539 case records of children in residential care in the three states, from which came the remaining findings.

Because information was sometimes not available on all variables for all children, many of the totals are not equal. In addition, as we mentioned in the first chapter, the results from the case records are nongeneralizable.

EXTENT OF NONGOVERNMENTAL PLACEMENTS

In the course of our interviews with state and county officials and experts in the area of residential care, we asked how pervasive they felt nongovernmental placements were. The responses ranged from "a handful of kids" to "about 50 percent of all placements." Judging from the results of our survey, the truth lies somewhere between these estimates.

A total of 478 facilities, representing a child population of 10,549, responded to our questionnaire. More than half of the responding facilities (286 or 60 percent) indicated that there was public involvement in the placement of all their child residents. The remaining facilities (192 or 40 percent) typically served children with and without public involvement in their placements. The latter category, i.e., nongovernmentally placed children, totaled 1,447 or 15 percent of children housed in the responding facilities. The numbers of children, broken down by type of placement for each state, are shown in table 7.

Table 7

Types of Placements Made for Children in Residential Care by State

	Nongovernmental		Governmental		Total	
State	No.	Percent	No.	Percent	No.	Percent
Florida	941	19	3,936	81	4,877	52
New Jersey	234	10	2,146	90	2,380	25
Wisconsin	272	13	1,810	87	2,082	22
Totals	1,447	15	7,892	85	9,339	100

FACTORS ASSOCIATED WITH TYPE OF PLACEMENT

From our case-record data, we are able to show relationships between a variety of factors and whether a child is placed in residential care through a governmental or nongovernmental process. One relationship is that between a child's family situation prior to placement and whether that placement is governmental or nongovernmental, as shown in table 8 on the following page.

Only 10 percent of nongovernmentally placed children are found in the category of "other" (i.e., wards of the state, living in foster homes with adopted parents, or living independently), while the corresponding figure for governmentally placed children is close to 30 percent. Clearly the family situation may influence how a child gets placed. For children in the "other" category, it is not unreasonable to assume that the majority of them are known to state and county agencies with responsibility for making placements. Hence, the observed association is logically plausible.

Table 8

Type of Placement by Family Situation of Child

Type of placement	Living with both parents		Living with single parent or other family member		Other		Totals	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Nongovernmental	24	34	39	56	7	10	70	100
Governmental	61	24	12	47	74	29	256	100
Totals	85	26	160	49	81	25	326	100

SOURCE: Case-record data

But, as table 9 shows, economic factors may also be involved. Here we see a relationship between type of placement and type of family income, with children coming from families with entitlement

Table 9

Type of Placement by Income Source of Child's Family

Type of placement	Income source					
	Salary		Entitled benefits		Totals	
	No.	Percent	No.	Percent	No.	Percent
Nongovernmental	53	90	6	10	59	100
Governmental	112	61	71	39	183	100
Totals	165	68	77	32	242	100

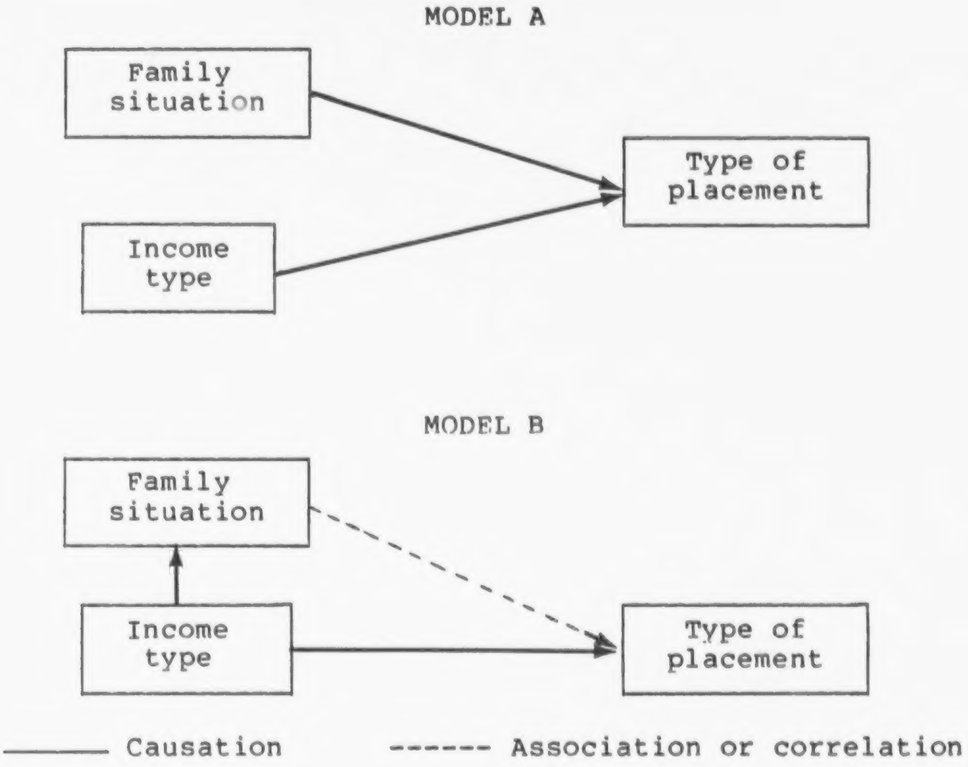
SOURCE: Case-record data

income (i.e., Aid to Families with Dependent Children, Supplemental Security Income, unemployment benefits, etc.) much more likely to go through a state or county agency to enter residential care than their counterparts whose families are employed.

An association or correlation between two factors is not synonymous with a cause-and-effect relationship. But neither does association or correlation preclude such a relationship, per se. Thus, without delving further into the question of causation, our findings are consistent with either a causal or correlative model, such as the two models presented in figure 19. It is impossible to tell, from our data, which of these is more accurate.

Figure 19

Relationship Between Family Situation, Income Type, and Type of Placement


MODEL A
Family situation
Type of placement
Income type
MODEL B
Family situation
Income type
Type of placement
Causation
Association or correlation

Either model would account for a relationship between family situation and type of placement. Model A, however, depicts that relationship as causal, while Model B gives an example of an indirect associative relationship.

Other variables we found associated with type of placement were:

- Whether the child had a criminal history, was Medicaid eligible, came from an abusive family, was considered violent, or had been placed in residential care before the current placement; and

- The incidence of status offenses.

These relationships are shown in figure 20 on the following page. Each set of bars shows a difference in the type of placement, according to the child's characteristics. Based on the results shown in tables 8 and 9 and figure 20, we can say the following about the children in our case-record sample:

- Children with histories of criminal activity or status offenses are more likely to enter residential care via a governmental placement than their counterparts without these activities in their backgrounds.

- The overwhelming majority (98 percent) of abused and violent children are governmentally placed.

- Most Medicaid-eligible children (93 percent) reach residential care with government involvement. Of those children not eligible, the division between the type of placement is much more equal (i.e., 46 percent nongovernmental, 54 percent governmental).

- The majority of the children who have no record of prior residential care get placed through nongovernmental processes. The reverse is true for children who have been in facilities prior to their current placements.

- Children from families whose primary source of income is entitlement benefits, as well as children without families, are more likely to be placed via government involvement.

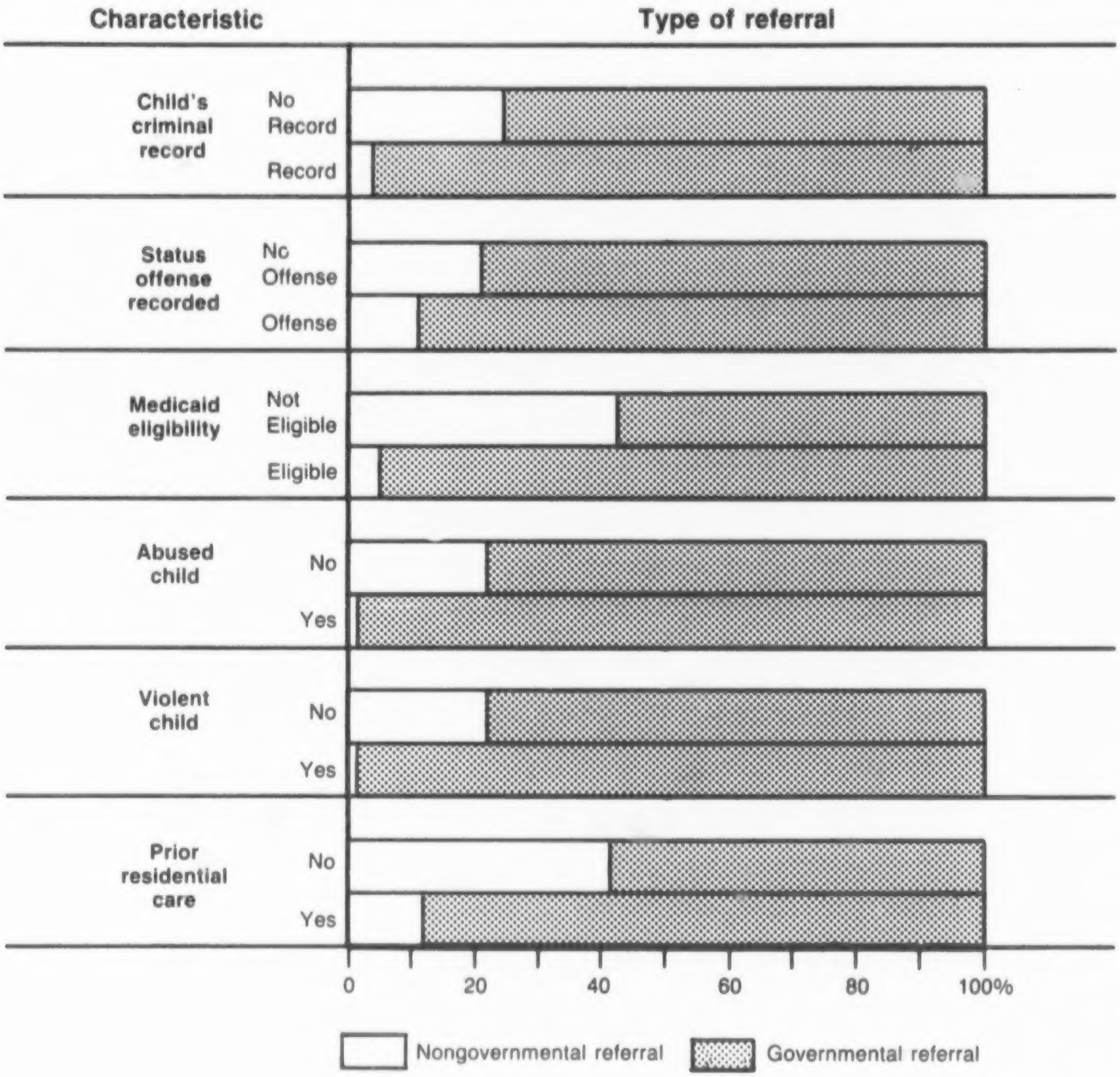
HEALTH INSURANCE AND RESIDENTIAL PLACEMENT

One point implicit in our distinction between governmental and nongovernmental placements is that in the latter the state or county directly assumes none of the financial burden of supporting the child. Given the significant costs involved in residential care, we wondered: who pays when the government is not involved? As figure 21 on the following page shows, private health insurance plans support close to 60 percent of children placed nongovernmentally, but they are relevant for only 12 percent of governmentally placed children.

The numbers are quite striking when one considers that, 1) of the 113 children placed nongovernmentally, more than three-quarters come from families with health insurance, while this is true for only a third of the 338 governmentally placed children; and 2) only 10 percent of children without insurance capability are placed in residential care with no public involvement.

Figure 20

Children's Characteristics Associated with Type of Referral (Governmental/Nongovernmental)[a]



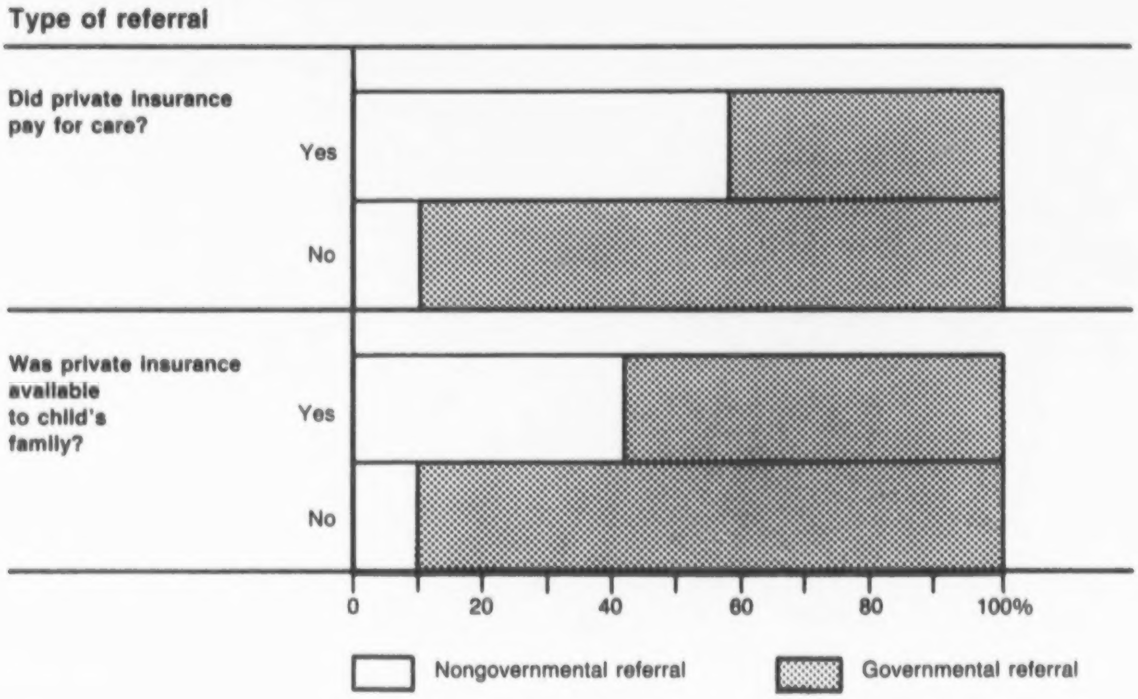
[a]Based on case study records of 539 children across the study states (Florida, New Jersey, and Wisconsin).

We believe the level of private health insurance support for nongovernmentally placed children is important for three reasons:

- The implication is that insured families have more options for acquiring residential services for their children than noninsured families, who must rely on state or county agencies;

Figure 21

Private Health Insurance Coverage and Availability for Residential Care by Type of Referral[a]



[a]Based on case study records of 539 children across the study states (Florida, New Jersey, and Wisconsin).

- The economic incentives of insurance plans, which pay for inpatient care, but often do not support group homes or day treatment programs, may lead to nonconformity with the principle of least restrictive form of intervention; and

- The expansion of insurance coverage to include inpatient psychiatric and substance abuse programs may well, as one study found, coincide with a dramatic increase in the number of children entering those programs.

RACE AS A FACTOR ASSOCIATED WITH PLACEMENT

Until now, this chapter has focused on factors associated with nongovernmental and governmental placements. In this concluding section, our interest returns to a different type of placement decision; i.e., whether the child is placed in a public or private facility. We refer to these as public and private placements, respectively.

Analysis of the facility data revealed that overall 47 percent of residents in public facilities were nonwhite, while 26 percent of residents in private facilities were nonwhite (derived from figure 15). One problem in interpreting this difference results from the relationship between placement type and auspice of facility; i.e., all nongovernmental placements are into private facilities, while governmental placements can be into either public or private facilities. The observed difference, therefore, in racial composition between public and private facilities may simply reflect higher levels of nonwhites going through governmental placements.

Our interest here, however, was not with the relationship between race and whether the child is governmentally or nongovernmentally placed, but rather between race and auspice of placement. For this reason, we employed data from only those facilities that indicated that all their child residents had reached care via a governmental process.

Among the 462 facilities that responded to this item, 62 percent (286) indicated that all their child residents had reached care via a governmental process. When we tested within this category for differential placement based on race, we found that the disparity in the percentage of nonwhites in public and private facilities remained (50 and 34 percent, respectively).

This disparity may result from the higher levels of minority children in the justice stream of care and the greater number of public facilities that are also justice-oriented. To test for this potentially confounding factor, we divided our sample once again, this time by stream of care. Also, to control for any influence state policies might have, we divided the sample by state.

The results are shown in table 10 on the following page and are structured to answer the question, "Of all white/nonwhite children in the sample within a particular stream of care or state, what percentage were placed in public facilities and what percentage in private?" With respect to stream of care, the results show that within both justice and health facilities the ratios of public to private facility placements for white and nonwhite children were approximately equivalent. This, however, was not true for welfare facilities, where most nonwhite children were placed in public facilities and the majority of white children were placed in private facilities.

Examining the results by state shows that New Jersey displays the same pattern as welfare facilities, with the majority of white children being placed in private facilities and almost three-fourths of all nonwhite children going to public facilities.

The reader should not conclude too quickly that these trends found with respect to welfare placements and New Jersey facilities are evidence of discriminatory or inappropriate placement practices. For example, the findings may result from higher concentrations of public facilities in urban areas, where there are heavier

Table 10

Racial Distribution of Children in Public and Private Facilities by Stream of Care and State[a]

Type of facility	White children No.	White children Percent	Nonwhite children No.	Nonwhite children Percent
By stream of care				
Welfare				
Public	579	48.6	329	60.1
Private	612	51.4	218	39.9
Justice				
Public	621	73.8	927	76.2
Private	220	26.2	290	23.8
Health				
Public	62	9.7	19	7.5
Private	578	90.3	234	92.5
By state				
Florida				
Public	825	66.7	768	69.4
Private	411	33.3	338	30.6
New Jersey				
Public	258	49.2	535	72.2
Private	266	50.8	206	27.8
Wisconsin				
Public	297	25.6	62	19.2
Private	864	74.4	261	80.8

[a] Data drawn from facilities in which all residents were placed by governmental processes.

concentrations of minority children, and the legitimate objective on the part of placing agents to keep children close to their homes. At the same time, we cannot conclude that discrimination based on race is not a factor in placement.

CHAPTER 6

SUMMARY

Our primary concern in this report has been with the four questions contained in Congressman George Miller's request:

1. What is the profile of existing residential care facilities?
2. What are the sources of the funds used to support these facilities?
3. What are the characteristics of the populations served at these facilities?
4. What factors influence the placement of children?

Presented below are summaries of our findings with respect to the four primary issues.

PROFILE OF FACILITIES

Of the 478 facilities we surveyed in our three states (Florida, New Jersey, and Wisconsin), the largest number (195) was located in Florida. Further examining the distribution of facilities, we found that

- Both Florida and Wisconsin facilities were predominantly private, whereas New Jersey had an equal number of public and private facilities;
- Most of the facilities in Wisconsin were in the welfare stream of care. In New Jersey and Florida, the largest numbers of facilities were in the health stream;
- Most of the facilities in the welfare and health streams were private, while in justice the overwhelming majority were public;
- Public facilities and facilities in the justice stream had shorter lengths of stay than did private, and welfare and health facilities, respectively. In addition, public and justice facilities had larger capacities and were closer to being filled to capacity than other facilities;
- Both public and private facilities had equivalent occupancy rates (i.e., 83 percent);
- The largest single source of referrals to facilities was the social service agency. Understandably, justice facilities had the greatest number of referrals from justice oriented agencies (i.e., police, courts, and corrections);

- Florida had a higher percentage of its children placed in care by families, while Wisconsin had a higher percentage placed by social service agencies than did the other states; and

- The majority of children leaving residential care were released to their families. Children leaving the justice stream showed the highest rate of release to family.

FINANCING OF RESIDENTIAL CARE

That public monies are the primary funder of residential care was our most consistent finding. This was the case in each of the three states, in each of the three streams of care, and in both public and private facilities. Even privately operated facilities received, on average, 74 percent of their funds from public sources. Other findings included the following:

- Charity (e.g., endowment) and private sources (e.g., parents and health insurance) contributed more to facility budgets in Florida than in New Jersey or Wisconsin.

- Health facilities received more funds from private sources than did welfare or justice facilities.

- Private facilities received more funds from private sources and charities than did public facilities.

- Cost of residential care is higher in health facilities than in welfare or justice facilities.

CHILDREN'S CHARACTERISTICS

The responding facilities in our 3-state study held a total of 10,549 children, more than half of them in Florida facilities. To summarize the major client characteristics:

- Three-quarters of all children placed were male and two-thirds were white.

- Nearly half of the children were between the ages of 12 and 15.

- Two-thirds of the children had families whose annual incomes were less than $15,000.

- Nearly half of New Jersey's placements were in the justice stream, while the majority of placements in Florida and Wisconsin were in the welfare stream.

- Except for Wisconsin, most placements for males were into the justice stream. The welfare stream was most often the place of care for males in Wisconsin.

- Nonwhite children were placed in residential care at higher rates than white children, relative to their proportions of state populations. This was true in all three states.

- In all states, the majority of residents in justice facilities were nonwhite. Wisconsin, however, had more nonwhites in the welfare stream than in justice or health.

- In each state, over 70 percent of residents in health facilities were white.

- In New Jersey, nonwhite children were placed more often in public facilities than private. White children were more often placed in private facilities.

WHAT FACTORS INFLUENCE PLACEMENT?

We found strong associations between type of placement (governmental or nongovernmental) and several other factors. Children with governmental involvement in their placements tended to have the following profiles: they more often had criminal or status offense histories, prior residential experiences, experiences with abuse, were considered violent, and/or were Medicaid eligible. On the other hand, children whose families had private medical insurance available to them were more frequently placed via a nongovernmental process.

In addition, of those children who had been placed by state or county agencies, we found that significantly higher percentages of whites went to private facilities and nonwhites to public facilities.

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July 28, 1982

The Honorable Charles A. Bowsher
Comptroller General of the United States
441 G. Street, N.W.
Washington D.C. 20548

Dear Mr. Bowsher:

I am writing to request that the General Accounting Office undertake an analysis of patterns of placement of children and youth in a variety of residential care facilities.

Over the course of the last decade a wide range of Congressional initiatives has addressed the needs of our youth population. These policies have been concerned with children and youth who enter the child welfare, juvenile justice, mental health, and special education systems. Significant federal funds have been allocated to provide services for these populations, many of whom have common needs.

Newly emerging evidence, however, suggests that we need to review the way both funding and placement policies in these systems are related to one another, particularly with respect to residential care facilities established or maintained with Federal funds. Specifically, I would like to be provided information on the following:

(a) A profile of existing residential care facilities (e.g. public and private inpatient mental health treatment programs, inpatient chemical dependency programs, group foster homes, juvenile correctional facilities).

(b) What are the sources of the funds used to support these facilities (e.g. private payments, State or Federal funds, third party payments)?

(c) What are the characteristics of the populations served at these facilities?

(d) What factors influence the placement of juveniles in each type of facility (e.g. economic status, space availability, funding sources, discretion of facility operators)?

Honorable Charles A. Bowsher
page 2
July 28, 1982

In a recent discussion with staff from your Institute for Program Evaluation, I learned that a newly tested methodology -- Program Operation and Delivery of Services Examination -- may be particularly appropriate for answering many of our questions.

I look forward to working with your staff during the course of this study to identify more specifically the scope of work to be performed. Please feel free to contact Ann Rosewater of my staff concerning this inquiry.

I appreciate your prompt attention to this matter.

Sincerely,

George Miller

GEORGE MILLER
Member of Congress, 7th District

GM/dp

RECEIVED
GAC-OCR

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Forward for Divisi[illegible]

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Advance Copy to:

☒ For action
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☒ For info Bowsher
Socolar, Keller
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Ahart, Anderson
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OCR will ack.

By [illegible] Date: 8/3/82

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DEVELOPMENT OF THE FACILITY MAILING LIST

This appendix describes the method by which residential child care facilities were identified and included in our study of such facilities in Florida, New Jersey, and Wisconsin. To be included in the study, facilities had to

1. be residential. Facilities of a temporary nature, such as shelters for runaway youth, were excluded if it was clearly known that this was their only purpose. If uncertainty existed, these facilities were included in our universe with a provision made in the survey instrument (appendix III, question 13) to identify them.

2. serve children (i.e., individuals 18 years of age or younger).

3. if a hospital, have a psychiatric and/or alcoholism/chemical dependency inpatient unit that serves children. Hospitals posed a special problem because of inpatient stays associated with general acute-care for children. To avoid including all children in hospitals, the scope of hospital participation was limited to only those with inpatient psychiatric and/or substance abuse units.

We made every effort to obtain as complete a listing as possible of residential facilities operating in each of the three states. Obtaining the names and addresses of facilities involved consulting with a number of individuals and directories. Initially, a series of interviews was scheduled with state officials responsible for the care of children. These officials outlined to us the mechanisms by which children enter into residential care. Different types of facilities are possible for child placements, according to the child's needs and history, the agency contacted, the point of entry into the placement system, etc. From each official, a list of facilities was obtained. Federal agencies were also contacted to determine if programs or funding existed for child care facilities. When available, facilities from federal sources were added to our developing list.

We obtained a list of hospitals, using the American Hospital Association Guide to the Health Care Field. Hospitals having inpatient psychiatric units (AHA facility code 27) and/or inpatient alcoholism/chemical dependency units (AHA facility code 48) were included in our study.

Because not all placements are public or known by public officials, it was necessary also to contact private social service agencies and associations for other facility names and addresses. After independently compiling this initial list of facilities, we contacted the University of Chicago's School of Social Service Administration. As explained in Chapter 2, the university completed in 1981 a national survey of residential group care facilities for children and youth. We requested and received their facility lists for each of our three states.

Having compiled names and addresses, we reviewed the list for obvious duplicates, using several methods of comparison. With the aid of a computer, facilities were first sorted alphabetically by name, street address, city, and zip code. Where a match occurred, the listing with the most complete information was retained. Having eliminated these duplicates, one further sort was done by telephone number. This proved especially helpful in uncovering possible duplicates (facility names sometimes varied across different sources, or the name had changed, which was reflected in one organization's source document, but not another's). When the names differed considerably, we would call the facility to determine the correct name and whether or not it shared its site with another.

Some individual facilities are a part of a number of others under the administrative offices of a parent organization. Consequently, our list would sometimes include an administrative office. Facilities would have the same name, but different addresses, or different names with the same address, or shared telephone numbers. Confusion was resolved and the appropriate mailing addresses obtained through telephone contacts with these facilities.

Thus, before mailing out our questionnaire, we made every effort to arrive at an exhaustive list of all residential facilities in the three states. To determine whether additional facilities did exist, however, we included five questions (numbers 2, 3, 7, 8, and 10) that probed this subject further. As the returns were received, we checked any information supplied against the master mailing list, but identified only a few additional facilities. The results of the mailing are shown in table 11.

Table 11

Residential Care Facilities Contacted, Responding, and Included in Study

	Total	Florida	New Jersey	Wisconsin
No. of questionnaires orginally mailed	1,514	548	547	419
No. returned (percentage)	1,332 (88.0)	474 (86.5)	486 (88.8)	372 (88.8)
No. of facilities included in study[a]	478	195	126	157

[a] Many facilities that returned questionnaires were eliminated from the study. Excluded facilities were those that were no longer in operation, served only adults, or operated as a day facility.

If a question arose during the development of our mailing list about whether to include a facility or not, we decided in favor of inclusion. Unless there was a clear and justifiable reason to exclude a facility, we felt it best to allow the questionnaire to act as the screening device. This proved to be fortuitous, in that we were able to discover some facilities for children that were originally indicated to be exclusively for adults.

FACILITY QUESTIONNAIRE

This appendix contains the questionnaire that we mailed to residential child care facilities in Florida, Jew Jersey, and Wisconsin, as well as the cover letter used.

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

INSTITUTE FOR PROGRAM
EVALUATION

Dear Director:

The U.S. General Accounting Office, an agency of the U.S. Congress, is examining patterns of placement of children and youth outside the home, primarily in residential care facilities. The purpose of this review is to provide Congress with descriptive information about the characteristics of facilities and their residents.

As part of this study we are asking facilities in Florida, New Jersey, and Wisconsin to complete this questionnaire. Most items in this short questionnaire can be completed easily by checking a box or writing a few words. Please note that we are defining "children/youth" as individuals under 21 years of age.

If you receive this questionnaire and are not directing a residential program for children and youth, but there is another unit or program within your facility that does, please forward this questionnaire to that individual.

Please complete and return this questionnaire within two weeks. A postage paid envelope is enclosed for your convenience. If you have any questions please call George Silberman collect at (202) 275-8499.

The information provided by your facility and all other facilities is an essential element for this review. Your timely cooperation will help us provide the information that Congress requires.

Sincerely,

Carl E. Wisler

Carl E. Wisler
Associate Director

Survey of Residential Placement of Children & Youth*

Person Completing Questionnaire: ____________________________

Telephone Number: ____

Date Completed:____

This questionnaire refers to the program specified in the mailing label above. Please complete the questionnaire only for the program named on that label. Please check the label and correct any inaccuracies.

Should you have any questions about the questionnaire, please call George Silberman collect at (202) 275-8499.

In order for timely use of this data, it is important that you return the completed question naire within two weeks of receipt.

Thank you for your cooperation.

*Children/youth are defined as individuals 18 years of age or less.

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I. General Facility Information

1. Does your facility currently provide residential services exclusively to children/youth, to children/youth as well as adults, or exclusively to adults? (Check one.) (16)

   a. ☐ Exclusively to children/youth

   b. ☐ To children/youth as well as adults

   c. ☐ To adults only. (If you provide services exclusively to adults please STOP HERE AND RETURN THE QUESTIONNAIRE.)

2. Is your facility administratively independent or part of some larger organization? (Check one.) (17)

   a. ☐ Independent (Skip to Question 4.)

   b. ☐ Part of some larger organization

3. What is the name and address of that larger organization?

   Name: ______________________________

   Address: ______________________________

   ____

4. Is your facility publicly or privately operated? (Check one.) (18)

   a. ☐ Publicly (Skip to Question 6.)

   b. ☐ Privately

5. Is your facility religiously affiliated or secular? (Check one.) (19)

   a. ☐ Religiously affiliated

   b. ☐ Secular

6. Is your facility operated as a for profit or as a not-for-profit organization? (Check one.) (20)

   a. ☐ For profit

   b. ☐ Not-for-profit

7. Are the services to children and youth provided in a distinct unit (for example -- a child and adolescent unit within a hospital)? (21)

   a. ☐ Yes (If yes, please answer all the following questions as they pertain to that child unit.)

   b. ☐ No (Skip to Question 10.)

8. Is this the only unit within your facility that provides residential services to children and youth? (22)

   a. ☐ Yes (Skip to Question 10.)

   b. ☐ No

9. What is the name of the other unit(s) and who is the director(s)?

   Unit Name: ______________________________

   Director: ______________________________

   Unit Name: ______________________________

   Director: ______________________________

10. In what year did the facility/unit begin to provide services to children/youth? (23-25)

    ____
    Year

11. Listed below are several types of residential care facilities. Which one best describes your facility? (Check one.) (26-27)

a. ☐ Foster family home

b. ☐ Drug & alcohol treatment program

c. ☐ Halfway house

d. ☐ Group home, other than foster family home or halfway house

e. ☐ Shelter facility (temporary)

f. ☐ Residential treatment center

g. ☐ Diagnostic & evaluation center

h. ☐ General hospital

i. ☐ Psychiatric hospital

j. ☐ Detention facility

k. ☐ Training school

l. ☐ Special education school

m. ☐ Correctional institution

n. ☐ Other (Please specify) ____________

____

12. Is your facility accredited by the Joint Commission on Accreditation of Hospitals (JCAH)? (28)

a. ☐ Yes

b. ☐ No (Skip to Question 14.)

13. In what year did your facility receive accreditation? (29-30)

____

14. Listed below are several objectives of residential care facilities. Which of the following best describes the primary objective of your facility as far as children/youth? (Check one.) (31-32)

a. ☐ Care of dependent/neglected/abused children/youth

b. ☐ Detention of children/youth

c. ☐ Care of delinquent children/youth

d. ☐ Care of status offenders

e. ☐ Care of children/youth with substance abuse problems (alchohol or other drugs)

f. ☐ Psychiatric care of mentally ill or emotionally disturbed children/youth

g. ☐ Other forms of care for mentally ill or emotionally disturbed children/youth

h. ☐ Diagnosis, testing or evaluation of children/youth

i. ☐ Care, treatment, training or education of mentally retarded or developmentally disabled children/youth

j. ☐ Care, treatment, training or education of physically handicapped children/youth

k. ☐ Boarding school education for children/youth with special problems other than mental retardation, developmental disabilities, physical handicaps or chronic illness

l. ☐ Other (Please specify) ____________

____

____

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15. Listed below are several objectives of residential care facilities. Please indicate whether or not each is currently an objective of your facility as far as children/youth are concerned. (Check one box for each objective.)

	Yes	No	
Care of dependent/neglected/abused children/youth	☐	☐	(33)
Detention of children/youth	☐	☐	(34)
Care of delinquent children/youth	☐	☐	(35)
Care of status offenders	☐	☐	(36)
Care of children/youth with substance abuse problems (alcohol or other drugs)	☐	☐	(37)
Psychiatric care of mentally ill or emotionally distrubed children/youth	☐	☐	(38)
Other forms of care for mentally ill or emotionally disturbed children/youth	☐	☐	(39)
Diagnosis, testing or evaluation of children/youth	☐	☐	(40)
Care, treatment, training or education of mentally retarded or developmentally disabled children/youth	☐	☐	(41)
Care, treatment, training or education of physically handicapped children/youth	☐	☐	(42)
Boarding school education for children/youth with special problems other than mental retardation, developmental disabilities, physical handicaps or chronic illness	☐	☐	(43)
Other (Please specify.) ______________________	☐	☐	(44)
______________________	☐	☐	(45)
______________________	☐	☐	(46)

II. Population

16. What is the rated capacity of your facility/unit? (47-49)

____

17. During your most recent annual reporting period, what was the average daily census of the facility/unit? (50-52)

____

18. Using the age groups below please indicate how many males and females, in each age category are currently residents of your facility/unit. (Please enter a number for each group. If none, enter "0".)

	Males	Females
a. Less than 2 years old	______ (1-2)	______ (3-4)
b. Between 2 and 5 years old	______ (5-6)	______ (7-8)
c. Between 6 and 11 years old	______ (9-11)	______ (12-14)
d. Between 12 and 15 years old	______ (15-17)	______ (18-20)
e. Between 16 and 18 years old	______ (21-23)	______ (24-26)
f. Between 19 and 21 years old	______ (27-29)	______ (30-32)
g. Over 21 years old	______ (33-35)	______ (36-38)
Total	______ (39-41)	______ (42-44)

19. How many of the current residents 18 years of age or less belong to each of the following racial/ethnic groups? (Please enter a number for each group. If none enter "0".)

American Indian	________	(45-47)
Asian	________	(48-50)
Black	________	(51-53)
Hispanic	________	(54-56)
White	________	(57-59)
Total	________	(60-62)

20. Listed below are several types of individuals and organizations that might refer children/youth to residential care facilities. Consider the current residents 18 years of age or less. Please indicate the number of these residents who were referred to your facility by each of the following referral agents. (Enter a number for each. If none, enter "0".)

Referral Agent	Number of children/youth	
a. Self	________	(1-3)
b. Parent/guardian/other family member	________	(4-6)
c. Clergy	________	(7-9)
d. Private psychiatrist/ physician	________	(10-12)
e. Private social service agency	________	(13-15)
f. Public social service agency	________	(16-18)
g. Inpatient psychiatric/ mental health treatment facility	________	(19-21)
h. Outpatient psychiatric/ mental health treatment facility	________	(22-24)
i. Police Department	________	(25-27)
j. Juvenile, family court	________	(28-30)
k. Criminal court	________	(31-33)
l. Probation department or correctional facility	________	(34-36)
m. General health care facility	________	(37-39)
n. School or education department	________	(40-42)
o. Other (Please specify)		
____________________	________	(43-45)
____________________	________	

21. Does your facility currently accept children/youth placed in residential care by State, county or local government agencies? (Check one.) (46)

a. [ ] Yes

b. [ ] No

22. Does your facility currently accept children/youth placed in residential care by private individuals or social service agencies? (Check one.) (47)

a. [ ] Yes

b. [ ] No

23. We would like to know how often public (state, county, local) agencies are involved in the placement of children/youth in your facility. By "involvement" we mean that a public agency directly placed the individual, referred the individual for placement, or approved/authorized the individual's placement. Using this definition of involvement, how many of the children/youth currently in your facility fall into each of the following categories? (Enter number.)

a. ________ Children with public agency involvement in placement (48-50)

b. ________ Children without public agency involvement in placement (51-53)

24. For your current residents, please indicate the number of children/youth in each of the following living arrangements immediately prior to admittance to your facility/unit?

a. With parents	______	(54-56)
b. With other biological family members	______	(57-59)
c. With foster family	______	(60-62)
d. At a public facility	______	(63-65)
e. At a private facility	______	(66-68)
f. Independent living arrangements	______	(69-71)
g. Prior living arrangement unknown	______	(72-74)

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25. For the children/youth currently in your facility, please indicate the number of your residents whose family incomes fall in each of the following categories.

a. Less than $7,000 ____________ (1-3)

b. More than $7,000 but less than $15,000 ____________ (4-6)

c. More than $15,000 but less than $25,000 ____________ (7-9)

d. More than $25,000 but less than $40,000 ____________ (10-12)

e. $40,000 or more ____________ (13-15)

III. Resident Activities & Staffing

26. Below is a listing of possible activities that may be available for the children and youth in residence. For each activity please indicate whether it is available, and, if available how many of the children/youth currently in residence regularly participate.

Activity	Available		If Yes, Number who who regularly participate	
	Yes	No		
a. Academic education				(16) (17-19)
b. Resident self government				(20) (21-23)
c. Recreational activities * Gymnasium				(24) (25-27)
* Outdoor sports				(28) (29-31)
* Movies				(32) (33-35)
* Swimming pool				(36) (37-39)
* Other (Please Specify) ____________				(40) (41-43)
d. Vocational training				(44) (45-47)
e. Library				(48) (49-51)
f. Psychotherapy				(52) (53-55)
g. Group therapy meetings				(56) (57-59)
h. Family therapy sessions				(60) (61-63)
i. Religious services				(64) (65-67)
j. Arts & crafts programs				(68) (69-71)
k. Life skills training				(72) (73-75)

27. How many children/youth currently in residence attend public schools?

____
(1-2)

28. How many of the children/youth currently in residence receive psychotropic medication?

____
(3-5)

29. For each staff category below please indicate how many full time equivalents (FTE's)* of each type are currently employed. Please include permanent and temporary staff, consultants and contractors.

Staff Category	FTE	
a. Administrative staff	______	(6-8)
b. Treatment, education and medical staff	______	(9-11)
c. Security staff	______	(12-14)

30. If your program currently uses volunteers please indicate the total number of hours per week they serve in each category.

Staff Category	Hours Per Week	
a. Administration	______	(15-17)
b. Treatment/education	______	(18-20)
c. Medical services	______	(21-23)
d. Other (Please specify)	______	(24-26)
__________		
__________		
Total	______	(27-30)

*Each full time equivalent is considered to work a 40 hour week.

IV. Facility Security

31. Listed below are several security measures which may be taken at residential care facilities. Please indicate if each measure is routinely used at the current time for the children/youth in your facility.

	Yes	No	
a. Locked security fence surrounds the facility grounds			(31)
b. Windows have security bars/screens			(32)
c. Curfew is enforced requiring residents to be on facility grounds at specified times			(33)
d. Secure isolation rooms are available			(34)
e. Children are searched upon return to the facility/unit			(35)

32. Listed below are several activities that may be permitted in residential care facilities. What proportion of your residents are routinely permitted to engage in these activities?

Activity	Proportion				
	All	Some	Few	None	
a. Move about the facility unaccompanied by a staff member					(36)
b. Make unmonitored telephone calls at their own discretion					(37)
c. Leave the facility grounds unaccompanied					(38)
d. Spend the night with parents/guardian					(39)

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33. How many children/youth committed or attempted to commit suicide during the last annual reporting period?

Number of children/youth who committed suicide ________ (40-41)

Number of children/youth who attempted suicide ________ (42-43)

34. Are the children/youth allowed to have spending money in their possession? (Check one.) (44)

a. ☐ Yes

b. ☐ No (Skip to Question 36.)

35. Is there a limit to the amount of money the children are allowed? (Check one.) (45)

a. ☐ Yes

b. ☐ No

V. Discharge Data

36. During the last annual reporting period how many children/youth were released from your facility/unit? (46-49)

____

37. Please indicate the number of these children/youth released to each of the following living arrangements.

a. Biological parents ________ (50-52)

b. Other biological family members ________ (53-55)

c. Adoptive parents ________ (56-58)

d. Foster family ________ (59-61)

e. Public facility ________ (62-64)

f. Private facility ________ (65-67)

g. Independent living ________ (68-70)

Total ________ (71-74)

38. Does your program conduct any follow-up services for residents discharged? (Check one.) (75)

a. ☐ Yes

b. ☐ No (Skip to Question 42.)

39. How often are these follow-up contacts made with the discharged residents? (For those programs with different follow-up programs for residents please give the average of that follow-up.) (76)

a. ☐ 2 or more times per week

b. ☐ Weekly

c. ☐ 2 or more times per month

d. ☐ Monthly

e. ☐ Less than monthly

40. What is the average length of time these follow-up services are continued? (Check one.) (77)

a. ☐ 1 month

b. ☐ 3 months

c. ☐ 6 months

d. ☐ More than 6 months

e. ☐ Other (Please specify) ________________

____

____

41. For what purpose or purposes does your program conduct follow-up services?

____

____

____

____

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42. Consider all children/youth who were released from your facility during your last annual reporting period. Approximately what proportion of this group are in each of the following length of stay categories? (Enter the percent for each category listed. If none, enter "0".)

Length of Stay at your facility	Percentage	
a. 1 - 7 days	______%	(1-2)
b. 8 - 30 days	______%	(3-4)
c. 31 - 60 days	______%	(5-6)
d. 61 - 90 days	______%	(7-8)
e. 91 - 120 days	______%	(9-10)
f. Over 120 days but less than 1 year	______%	(11-12)
g. More than 1 year but less than 2 years	______%	(13-14)
h. More than 2 years	______%	(15-16)

VI. FINANCIAL INFORMATION

43. What is the approximate size of your facility's total budget during this fiscal year. (Check one.) (17-18)

a. ☐ Under $50,000

b. ☐ $50,000 - $99,999

c. ☐ $100,000 - $249,999

d. ☐ $250,000 - $499,999

e. ☐ $500,000 - $749,999

f. ☐ $750,000 - $999,999

g. ☐ 1 - 1.9 million dollars

h. ☐ 2 - 2.9 million dollars

i. ☐ 3 - 5 million dollars

j. ☐ More than 5 million dollars

44. What is the average daily cost per child/youth in the facility? (19-22)

$______________

Enter dollar amount

45. Does this include the cost for educational schooling? (23)

a. ☐ Yes

b. ☐ No

46. Please indicate the approximate percentage of the current operating budget derived from each of the following sources. (Enter percent. If none, enter 0)

a. Charitable contributions from private or corporate donors	______%	(24-25)
b. Funds from federated fund-raising bodies such as the United Way	______%	(26-27)
c. Endowments or investments	______%	(28-29)
d. Payments for services by parents of children/youth residents	______%	(30-31)
e. Payments for services by private agencies that place children/youth in your facility	______%	(32-33)
f. Monies from state or local governments	______%	(34-35)
g. Grants from Federal government	______%	(36-37)
h. Public third party insurance (i.e., CHAMPUS, Medicaid, SSI)	______%	(38-39)
i. Private third party insurance (e.g., Blue Cross, Prudential etc.)	______%	(40-41)
j. Other (Please specify) ______________________ ______________________	______%	(42-43)
k. Total	100 %	

47. Please indicate the ending date for your last annual reporting period. (44-49)

_____/_____/_____
Day Month Year

CASE RECORD REVIEW AND SURVEY INSTRUMENT

We examined the case records of 539 children in 46 facilities in the three states of our study. Although our facility questionnaire (see appendix III) provided summary characteristics of the children in care, responses to each question represented aggregate data for all children in a particular facility. Case records provided individual-level data that could be used to study interrelationships among variables. Further, the use of case records enabled us to examine other important information concerning the child's placement history, family socioeconomic characteristics, and sources of payment for his or her out-of-home placement that were not possible with the facility quesionnaire.

For the case-record review, facilities were picked to include psychiatric, drug, and other types of care in each state. Facilities were not chosen in such a way as to be representative of all facilities of a specific type in a given state, however. Therefore, the 539 records examined do not permit drawing inferences beyond those selected. Other items of consideration in picking sites (in addition to type of care provided by facilities) included staffing, timing, and geographic constraints.

Two criteria were used to select case records: 1) If the facility had 20 or fewer children in residence, each record would be reviewed, and 2) if a facility had more than 20 residents, up to 20 records would be sampled. The method used in selecting case records varied by the size of the population (e.g., if a facility had 40 children, every other case record was selected; if a facility had 100, every fifth record would be chosen, etc.). The numbers of facilities we sampled and case records examined are as follows:

	Total	Florida	New Jersey	Wisconsin
No. of facilities	46	13	16	17
No. of case records	539	147	218	174

From each case record, we encoded selected data, utilizing the following form. These data formed the basis for our observations in chapter 5 concerning types of placement.

Facility:______________________________

Date:_______IPE reviewer:______________
IPE job# 973175

1. Age:____

2. Sex:____

3. Race:___________

4. Income:______________

5. Length of stay:_________________

6. Reason for placement:

Dep., Neg., or abused______	Emotionally disturbed______
Criminal offense_____	Diagnosis, test or evaluation_____
Status offense_____	MR or DD_____
Alcohol_____	Physically handicapped_____
Drugs_____	Mentally ill_____

7. Severity of problem:

Very_____ Somewhat_____ Not severe_____

8. Who pays: Primary______________________________%

Secondary______________________________%

9. Cost of care: Average $______________

Billable $_____________

10. Availability of insurance:

Private coverage: Yes____Name of plan:_________________
No_____
Medicaid eligible: Yes_____ No_____

11. First out of home placement? Yes_____ No_____

12. Number of previous placements:_____

13. Details of previous placements:

1.____
2.____
3.____
4.____

14. Where was individual prior to current placement?

15. Prior participation in nonresidential program?

Yes_____ Type____

No_____

16. Was state, county, or municipal agency involved in placement?

Yes_____ Which one(s)________________________________

No_____ Self_____

Family_____

Private agency_____

17. Facility type:_______________________________________

Other observations, notes, continuations:
****

STATE REVIEWS

A draft copy of this report was sent for review to five state or county officials with responsibility in the field of residential care for children. Three of the recipients submitted comments to GAO, copies of which follow.

As can be seen from their comments, the reviewers generally supported the findings of this study and were positive in their reactions to the report. One reviewer raised issues concerning our stream of care typology and our characterization of all monies supplied by county agencies to facilities as "public" funds. We addressed these comments by 1) indicating in the body of this report that we categorized facilities according to the information they provided us on populations served and services provided, not necessarily using "official" terminology (p. 12); and 2) clarifying that our examination of funding sources was limited to direct sources and that this could lead to situations in which funds originating with parents might be categorized as public (p. 23).

Following are the letters received.

HRS STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

February 26, 1985

Mr. George Silberman
Project Manager
Program Evaluation and
Methodology Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Silberman:

Thank you for the opportunity to review and comment on the draft study of Residential Care for Children and Youth in Three States, recently completed by your office.

The findings of your study substantiate our own data on residential care of children, particularly as it relates to children's characteristics and the factors influencing placement. This supporting documentation will add weight to our efforts to improve residential care for children in our state. The study is thorough and comprehensive and I offer no suggestions for change.

Thank you for sharing this material with me. The contribution made by this report to improve the residential care of children is appreciated. I am looking forward to receiving your final report in order to share it with key people in our state.

Sincerely,

Dave May
Program Administrator
Children, Youth and Families
Program Office

DM/MAP/cjp

DEPARTMENT OF SOCIAL SERVICES

Milwaukee County

THOMAS A. BROPHY • Director

March 5, 1985

Mr. George Silberman
Project Manager
United States General
Accounting Office
Washington, DC 20548

Dear Mr. Silberman:

Thank you for the opportunity of responding to the draft of your report "Residential Care for Children in Three States: Placement Varies By Facility And Child Characteristics."

Since you are primarily reporting your research findings, it would be difficult for me to challenge them. I do, however, question the high number of Wisconsin institutions which are listed as "welfare," rather than "health." Your questions (#14,15) are somewhat ambiguous as they relate to Wisconsin. We no longer have the legal categories of dependent, neglected and abused children. Instead we have children in need of protection or services (CHIPS). Except for the very few children placed independently at parental or third-party insurance cost, institutional placements are the result of a court determination of CHIPS or delinquency. This precedes placement into facilities which provide care, treatment, training and education of mentally ill, emotionally disturbed, and developmentally disabled children. Therefore, it presents an unfair choice between your "welfare" and "health" categories for Wisconsin facilities. My experience with facilities in this state is that, given the either or choice, more programs would be primarily "health."

I would also like to comment on your financial sections. You show what appear to be three discrete funding sources--government, parent, insurance. In Wisconsin, whenever we make a governmental placement we also assess the parental ability to contribute to the cost of care. This is figured against a state scale. At the present time there is a ceiling of $183 per month, but there are several counties (including Milwaukee) which have pilot projects which have removed that ceiling. What usually happens is that the county or state makes the payment to the institution and then collects from the parent. The institution would thus show government as its funding source. It is important to recognize in your report that there is this parental contribution even where government funding is the primary payment source.

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JAMES W. WAHNER, DIRECTOR
Department of Health and Human Services
PHONE NUMBER FOR THE HEARING IMPAIRED 289-6111

456 R11

Mr. George Silberman
Page 2
March 5, 1985

I hope you will share with us a copy of your completed report.

Sincerely,

Patricia Towers

Patricia Towers
Associate Director

PT:RS:ts

cc: E. Messinger
R. Safer

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ROCK COUNTY DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 1649
JANESVILLE, WISCONSIN 53547-1649
608/756-5255, Janesville
608/365-6691, Beloit

March 6, 1985

George Silverman
Project Manager
Program Evaluation & Methodology Division
United States General Accounting Office
Washington, D.C. 20548

Re: Your Draft Report on Children in
Residential Care in Florida,
New Jersey and Wisconsin

Dear Mr. Silverman:

Thank you for giving me the opportunity to review and critique this report. The Rock County Department of Social Services was pleased to have been of assistance to you in its role of participant in the project.

I found the report well done and entirely interesting; it was both thorough and comprehensive, and at the same time recognized some of the difficulties inherent in pursuing such a study (as in Chapter 4, The Placement Process). It is hoped the information contained in the report will encourage continuing interest in child welfare programs ((and funding thereof) by Congress as well as encourage efforts by states to monitor and evaluate their alternate child care systems. The true test of these programs is, of course, the quality and conditions of life of the child-turned-adult.

Incidentally, page X in the Introduction does not follow IX with any logic, although by now I'm sure you are aware of this.

Again, thank you for allowing us to be a part of this effort.

Sincerely,

Ursula S. Myers

Ursula S. Myers, ACSW
Director
Rock County Department of Social Services

cc: Board of Social Services
cc: Donald Upson
cc: Craig Knutson
cc: Severa Austin

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